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U.S. HOUSE OF REPRESENTATIVES

OVERSIGHT INITIATIVE REPORT

FROM THE

SUBCOMMITTEE ON OVERSIGHT

ABUSIVE MARKETING PRACTICES BY DURABLE MEDICAL EQUIPMENT SUPPLIERS

INCLUDING FINDINGS AND RECOMMENDATIONS OF THE SUBCOMMITTEE

Report No. 5

NOVEMBER 7, 1991

Prepared for the use of the Committee on Ways and Means by its staff

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LETTER OF TRANSMITTAL

COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, D.C., November 7, 1991.

The Honorable DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR CHAIRMAN ROSTENKOWSKI: We are submitting to the Committee on Ways and Means the report of the Subcommittee on Oversight on Abusive Marketing Practices by Durable Medical Equipment Suppliers. This report was approved by the Subcommittee on a bipartisan basis on November 7, 1991, and is the result of the Subcommittee's investigation and hearing on problems involving the durable medical equipment (DME) benefit under the Medicare program. We respectfully request that the Committee on Ways and Means review the Subcommittee's report and take action on the Subcommittee's recommendations in a timely manner. The attached report provides a brief background on the issue reviewed, the scope of the Subcommittee's investigation and hearing, and the Subcommittee's recommendations for administrative and legislative changes.

The Subcommittee initially became interested in DME at its hearing on Medicare fraud during the 101st Congress. At a field hearing held in Fort Lauderdale, Florida, on July 30, 1990, the Subcommittee heard testimony about problems in the area of DME that the Regional Inspector General, Department of Health and Human Services (HHS), had encountered over the past five years, including high-pressure sales techniques to induce Medicare beneficiaries to obtain durable medical equipment that they did not really need. At a subsequent Subcommittee hearing in Washington, D.C., on September 25, 1990, the Inspector General of HHS reiterated his office's concern about abusive DME sales practices. Issues involving the DME were also raised by the Director, Office of Management and Budget, and the Deputy Inspector General, HHS, at the hearings held on May 8 and 9, 1991, by the Committee on Ways and Means on the effectiveness and efficiency of programs within the Committee's jurisdiction.

On June 21, 1991, the Subcommittee conducted a hearing in West Chester, Pennsylvania, regarding problems with the DME benefit. The Subcommittee received testimony from a variety of witnesses, including Medicare beneficiaries, a physician, a DME salesman, the U.S. Attorney, representatives of a DME industry association, the Medicare carrier, and the HHS Regional Office of the Inspector General. Foremost among the issues discussed was the problem of fraud by DME telemarketing firms. The Subcommittee

believes that there is a real problem with DME companies who use high-pressure, telemarketing-sales techniques to induce Medicare beneficiaries to purchase equipment that the beneficiaries neither want nor need. These companies often make misrepresentations regarding Medicare, frequently telling beneficiaries that they will not have to pay anything for equipment they order. (In fact, beneficiaries are responsible for 20 percent of the cost of equipment, and it is contrary to HHS rules and regulations for companies routinely to waive this copayment.) In short, what these telemarketers are really "pitching" is Medicare, not equipment. By telling beneficiaries that they are "entitled" to DME under Medicare, they are creating a demand for equipment that would not otherwise exist. In addition, the Subcommittee also received testimony about excessive prices paid by Medicare for certain items of DME, the poor quality of many items of DME, and the difficulties that Medicare carriers and law enforcement agencies have in pursuing companies engaged in DME-claims fraud.

The Subcommittee report contains the following recommendations:

1. That Medicare carriers deny Medicare provider numbers to DME suppliers who engage in telemarketing, i.e., suppliers who initiate unsolicited telephone calls to beneficiaries to induce them to buy equipment;
2. That Medicare carriers deny the use of more than one provider number to DME suppliers, and that the Health Care Financing Administration (HCFA) develop a questionnaire (which will be completed by DME suppliers applying for Medicare provider numbers) designed to alert Medicare carriers to potentially abusive DME sales practices;
3. That HCFA submit a report on the Medicare Pre-approval Program authorized in the Omnibus Budget Reconciliation Act of 1990, and that decubitus care mattresses be added to the list of items subject to the pre-approval process;
4. That, in order to eliminate "carrier shopping," Medicare carriers reimburse DME suppliers based on the fee schedule in effect for the residence or address of the beneficiary, rather than the fee schedule at the "point-of-sale";
5. That HCFA develop a standardized "Physician's Prescription for Durable Medical Equipment" to be used nationwide, containing information both from the supplier and the prescribing physician; that a completed copy of this form be delivered to the beneficiary; and that HCFA develop standardized equipment-specific forms for items of DME subject to abuse;
6. That Medicare carriers amend the Explanation of Medical Benefits form so that beneficiaries can clearly understand exactly what equipment has been paid for by Medicare;
7. That HCFA prepare a list of items of DME for which improved definitions or standards might be appropriate, together with recommendations regarding quality standards and definitional terms;
8. That Medicare carriers use current price information, including current wholesale prices, in making determinations regarding the inherent reasonableness of DME fee-schedule allowances; and that carriers immediately undertake inherent-rea-

sonableness determinations for five items of equipment believed to be overpriced or overutilized, including decubitus care equipment, transcutaneous electrical nerve stimulator (TENS) units, and other items selected by the Secretary of HHS;

9. That the DME report of the Comptroller General, as proposed in H.R. 1555, be expanded to include, for 150 items of DME, a comparison of supplier costs with the range of fee-schedule allowances for these items, an analysis of the appropriateness of a national fee schedule for DME, and a proposed timetable for implementation of a nationwide fee schedule; and
10. That HCFA review the items classified as "prosthetics and orthotics" to identify those items not requiring individualized, custom fitting and adjustment, and submit recommendations regarding the appropriate method for reimbursement of these items similar to other classes of DME.

The Subcommittee believes that the adoption of these recommendations will result in the elimination of abuses in Medicare, as well as in improved administration of the program.

Sincerely,

RICHARD T. SCHULZE,
Ranking Minority Member.

J. J. PICKLE,
Chairman.

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REPORT OF THE SUBCOMMITTEE ON OVERSIGHT ON ABUSIVE MARKETING PRACTICES BY DURABLE MEDICAL EQUIPMENT SUPPLIERS

BACKGROUND

Medicare is a Federal health insurance program, authorized under title XVIII of the Social Security Act, for people age 65 or older, certain younger disabled people, and people of any age with permanent kidney failure. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). Medicare has two parts: hospital insurance (Part A), which helps pay for necessary care provided by Medicare-approved hospitals, skilled nursing facilities, home health agencies or hospice programs; and supplementary medical insurance (Part B), which helps pay for medically necessary physician services, outpatient hospital services, certain home health care, and various medical services and supplies—including durable medical equipment (DME)—not covered by Medicare hospital insurance. Hospital insurance (Part A) is financed through the Federal Insurance Contributions Act (FICA) tax paid by employees, employers, and the self-employed. Medical insurance (Part B), which is voluntary, is financed through monthly premiums paid by enrollees and from Federal general revenues.

After services or supplies have been supplied to a Medicare beneficiary, the provider submits a Medicare claim. Claims are not processed by Federal employees. Rather, HCFA contracts with a network of health insurance organizations for the processing and payment of claims. Contractors processing supplementary medical insurance (Part B) claims are known as carriers. Thirty-four contractors serve as Medicare carriers. Of this number, 26 are Blue Shield organizations, and eight are other commercial insurers.

Under Part B, physicians and suppliers may bill for their services on either an "assigned" or "unassigned" basis. If a claim is "assigned," the beneficiary assigns to the physician or supplier his right to be reimbursed by the Medicare program. The physician or supplier then submits the claim to the Medicare carrier on behalf of the beneficiary and agrees to accept the carrier's determination of the allowed charge as payment in full. For durable medical equipment, the determination of the allowed charge is based on a "fee schedule," setting forth the amounts at which Medicare will pay for items of DME. Medicare carriers maintain a separate fee schedule for each locality.

Once the Medicare carrier has determined the amount that Medicare will pay for the equipment, the beneficiary is responsible for coinsurance—the percentage (20 percent) of the allowed charge that Medicare does not pay. For assigned claims, the physician may not charge the beneficiary more than the 20-percent coinsurance

amount. In addition, beneficiaries are responsible for the $100 deductible (the amount of covered medical expenses a beneficiary must pay before Medicare pays). For DME claims, HCFA estimates that approximately 92 percent are accepted on assignment.

If a claim is "unassigned," the provider is required to submit the claim to the contractor, but the contractor pays the beneficiary, who, in turn pays the provider. The beneficiary is responsible for the coinsurance amount, any unmet deductible, noncovered charges, and differences between the provider's actual charge and the Medicare-allowed charge. Providers who submit an unassigned claim do not accept the Medicare-allowed amount as payment in full, and may bill the beneficiaries for amounts in excess of the Medicare-allowed amount. For physician services, there are limitations on the amount a physician can charge a beneficiary for unassigned claims. This limitation is known as the "limiting charge" or "balance bill limit." When fully phased in, in 1993, the limiting charge for physicians will be 115 percent of the physician fee-schedule amount. Unlike physicians, DME suppliers are not subject to a limiting charge. The amount they may bill the beneficiary for unassigned DME claims is unlimited.

REASONS FOR SUBCOMMITTEE REVIEW

The Congress has been concerned for some time with problems involving durable medical equipment. In the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), the Congress made sweeping changes in the methods to be used in determining the calculation of reimbursement amounts for durable medical equipment. These changes were effective as of January 1, 1989. In the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) and the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the rules adopted in OBRA '87 were further refined.

In addition, OBRA '87, OBRA '89 and OBRA '90 addressed specific items of DME that were believed to be overpriced, overutilized, or subject to abuse. For example, in order to permit a physician to determine if the purchase of a transcutaneous electrical nerve stimulator (TENS) unit was medically appropriate, OBRA '87 authorized the Secretary of HHS (the Secretary) to determine an appropriate rental amount, so that the TENS unit could be rented for an initial two-month rental period before a decision was made regarding purchase of the TENS unit. OBRA '89 also directed the Secretary to reduce payment amounts for seat-lift chairs and TENS units by 15 percent. OBRA '90 reduced fee-schedule-payment amounts for TENS units by another 15 percent. In addition, OBRA '90 limited payment for seat-lift chairs to the seat-lift mechanism only.

The Subcommittee on Oversight received testimony about excessive reimbursements for DME at a hearing on Medicare fraud during the 101st Congress. At a field hearing held in Fort Lauderdale, Florida, on July 30, 1990, the Regional Inspector General for Investigations, Atlanta Field Office of HHS testified that in the past five years his office had seen major problems in the area of DME. Especially troublesome, he stated, were companies that used high-pressure sales techniques to get Medicare beneficiaries to

accept durable medical equipment that they did not need. He singled out seat-lift chairs and TENS units as major areas of DME abuse. TENS units, he indicated, cost about $59. Some Medicare carriers' fee-schedule amounts for TENS units, however, were in the neighborhood of $500.

At a further Subcommittee on Oversight hearing on Medicare fraud in Washington, D.C., on September 25, 1990, the Deputy Inspector General for Investigations of HHS, reiterated the Department's concern about DME abuse, stating that his office had seen a nationwide increase in problems with DME suppliers. He stated that he believed certain items of DME to be overpriced, and, as an illustration, he submitted a list of 19 items of DME, (Attachment A) comparing DME suppliers' costs with the amounts Medicare reimbursed for these items. The list included equipment such as a decubitus care mattress which cost the supplier $40, but for which Medicare reimbursed the supplier $434.95; and a moist electric heating pad for which the supplier paid $7.97, but for which Medicare paid $53.03.

At a hearing before the Subcommittee on Health on May 22, 1990, the General Accounting Office (GAO) testified regarding its study of 1989 DME fee schedules across the country. GAO had reviewed fee-schedule allowances for 46 separate items of DME. For 95 percent of these items reviewed, GAO found that the highest fee-schedule amount was twice as much as the lowest fee-schedule amount. For 40 percent of the items, GAO found the highest fee-schedule amount to be six times as much as the lowest fee-schedule amount. For example, the fee-schedule amount for the purchase of crutches was $20 in Virginia, $36 in Washington, D.C., and $72 in Baltimore, Maryland.

On May 8, 1991, at a hearing held by the Committee on Ways and Means on the effectiveness and efficiency of programs within the Committee's jurisdiction, one of the issues raised was the inflated prices paid by Medicare for items of DME. The Director, Office of Management and Budget, testified that this was a problem area. Disparities among carriers' fee schedules (and the attendant problem of "carrier shopping" by DME suppliers) was also raised as a problem area. In addition, at a full Committee hearing on May 9, 1991, the Deputy Inspector General of HHS testified that his office had documented fraudulent and abusive practices in the DME industry (including questionable marketing techniques, inflated charges, and manipulation of loopholes), in need of corrective action or program modification.

On June 13, 1991, in testimony before the Subcommittee on Health on the issue of Medicare fraud and abuse, the Inspector General of HHS again testified about abusive practices in the area of DME. He stated that his office was especially concerned about "carrier shopping." Carrier shopping, he stated, is possible because of the HCFA regulation stating that DME suppliers are to be reimbursed in accordance with the fee schedule in effect at the "point-of-sale." Point-of-sale is defined as the location at which the order for DME is received, i.e., the location of the DME supplier. By locating in a State with high DME reimbursement rates, suppliers can take advantage of geographic variations in DME fee schedules to maximize their profits. He also testified that by using high-pres-

sure, confusing, and misleading sales techniques, DME suppliers had coerced Medicare beneficiaries to order unneeded items of DME.

SUBCOMMITTEE INVESTIGATION AND HEARING

The Subcommittee on Oversight held a hearing on June 21, 1991, in West Chester, Pennsylvania on the issue of abusive DME practices. The Philadelphia area was selected as the site for the hearing because this region had been identified by the Inspector General of HHS as an area with a substantial amount of abusive practices. The Pennsylvania fee-schedule allowances for DME are among the highest in the nation. In addition, the Medicare carrier, Pennsylvania Blue Shield, was selected by HCFA as the site for a pilot program calling for pre-approval of certain items of durable medical equipment frequently used in abusive practices.

The Subcommittee hearing came at the close of a two-month investigation by Subcommittee staff, which included visits to the Medicare carrier, including interviews with carrier personnel responsible for processing DME claims, and field representatives responsible for responding to and investigating complaints from beneficiaries. Subcommittee staff also conducted interviews with personnel from HCFA, personnel from the regional offices of the Inspector General of HHS and personnel from the Office of the United States Attorney for the Eastern District of Pennsylvania. Subcommittee staff interviewed a substantial number of Medicare beneficiaries who had been induced by DME suppliers to order equipment, a former salesman from a high-pressure DME supplier, and several physicians, including a physician who admitted to signing certificates of medical necessity (CMNs) certifying that his patients were in need of DME, even though he had never discussed the matter with his patients.

Medicare Coverage of Durable Medical Equipment

Part B of Medicare entitles a beneficiary to have payment made on his behalf for "medical and other health services." Included within the definition of "medical and other health services" is "durable medical equipment." The Medicare laws do not provide a comprehensive list of items comprising covered "durable medical equipment." Rather, the law merely lists four examples of durable medical equipment, stating that the term "includes iron lungs, oxygen tents, hospital beds, and wheelchairs . . . used in a patient's home . . . whether furnished on a rental basis or purchased."

In the manual issued to Medicare carriers, HCFA has further defined the term "durable medical equipment" as equipment "which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home." If it can be clearly established that they serve a therapeutic value, some items of DME are covered under Part B even though they "are not primarily and customarily used to serve a medical purpose and even though they may be generally useful in the absence of illness or injury." Among such items are gel pads

and pressure and water mattresses. These items generally serve a preventive purpose, but Part B insurance will cover these items when they are prescribed for a patient who has bedsores. Other items (e.g., exercise equipment and grab bars) may be useful to a Medicare beneficiary, but will not be covered under Part B unless it is necessary and reasonable to treat an illness or injury.

Becoming a DME Supplier: Issuance of Provider Numbers to DME Suppliers

In order to be eligible to receive Medicare payments for DME furnished to Medicare beneficiaries, a DME supplier must obtain a Medicare provider number. Medicare carriers assign provider numbers to providers who furnish to Medicare beneficiaries services or supplies covered by Part B of Medicare. States play the primary role in determining the qualifications of many providers. Physicians, for example, must be legally authorized to practice in the State where they render services. For other types of providers—including DME suppliers—there are no such requirements. To obtain a Medicare provider number as a DME supplier, however, an applicant generally needs either only a Social Security number or an employee identification number.

Medicare carriers across the country do not have a uniform system for assigning provider numbers. Rather, each carrier has established its own system for assigning provider numbers. Some carriers do not even have an application form for DME suppliers. Some carriers assign a provider number to a provider upon submission of the first Medicare claim. Carriers that do require applicants to complete a form have had to develop their own forms. Because of the problems it has experienced with abusive DME telemarketers, Pennsylvania Blue Shield has developed a specialized form for applicants seeking a provider number as DME suppliers, seeking information about the suppliers' sales practices. This questionnaire is intended to help the carrier identify potentially abusive DME suppliers. (Attachment B)

Providers may—and often do—have more than one provider number. Multiple provider numbers may serve legitimate purposes. Physicians who have both a group and an individual practice, for example, may have a different number assigned to each practice. Multiple provider numbers, however, may also enable unscrupulous DME suppliers to escape scrutiny. Provider numbers, for example, are used to conduct utilization reviews. If orders for an inordinate amount of DME are originating with one DME supplier, multiple provider numbers may enable the carrier to escape detection of excessive utilization.

Submission of DME Claims for Payment: Certificates of Medical Necessity

A Medicare beneficiary may select an item of DME from a DME supplier, or the beneficiary's doctor may prescribe the DME. In any event, either a physician's prescription or a Certificate of Medical Necessity (CMN), signed by the beneficiary's physician, is generally necessary before Medicare will pay a claim for DME. When items are selected by a beneficiary from a DME supplier, the supplier

generally forwards the CMN to the beneficiary's physician for signature. For oxygen to be used in the home, HCFA has established a standard CMN for use by all carriers, so that the physician can document the need for oxygen. For other items of DME, however, there is no standard CMN form. Each carrier develops its own forms. Typically, a CMN reflects a beneficiary's diagnosis, and certifies the physician's judgment that the equipment is reasonable and necessary for treatment of the beneficiary's illness or injury. Attachment C is a series of CMN forms developed and used by one Medicare carrier, including specialized forms for wheelchairs, seatlift chair mechanisms, TENS units, and oxygen.

In the past, DME suppliers routinely filled out CMNs, including the patient's diagnosis and forwarded them to physicians. All the physician had to do was sign the CMN and return it to the DME supplier, who, in turn, submitted the CMN to the Medicare carrier when the Medicare claim form was filed. OBRA '90 prohibited DME suppliers from distributing to physicians or beneficiaries a "completed or partially completed" CMN. This provision, authorizing a penalty of $1,000 for each violation, was made effective as of January 1, 1991.

On May 1, 1991, HCFA issued a memorandum to carriers, instructing them on the implementation of this provision. HCFA instructions allow a DME supplier to complete the "administrative portions" of the form (identifying information pertaining to the supplier, beneficiary and physician) and to attach a cover letter with a complete narrative description of the specific equipment to be purchased. In addition, HCFA suggests that the DME supplier inform the physician of the charge for the DME equipment. Carriers are instructed not to deny DME claims for failure to meet the new requirements until September 1, 1991.

At the Subcommittee on Oversight's June 26, 1991, hearing, the Office of Inspector General of HHS testified that it had noticed several instances where DME suppliers, in an effort to evade this requirement, had sent blank CMNs to physicians, with notes or a sample form attached explaining how to complete each block of the CMN form. (Attachment D, for example, is a form forwarded to a physician by a DME telemarketer, along with a CMN. This form reflects the equipment "ordered" by the patient and the appropriate diagnoses that the doctor should indicate on the CMN form.)

Fraud and Abuse in the Sale of Durable Medical Equipment to Medicare Beneficiaries

At the Subcommittee on Oversight's hearing, the United States Attorney for the Eastern District and the Office of Inspector General of HHS outlined their concerns about Medicare fraud by DME supply firms in Pennsylvania. Of particular concern are companies that sell durable medical equipment to senior citizens by telephone. Typical of the problems was an operation which the U.S. Attorney had successfully shut down as the result of a civil suit brought against the DME supplier. In this operation, high school students were hired to telephone Medicare beneficiaries, some of whom had responded to a newspaper advertisement, offering a "free Medicare-covered package plus a new special courtesy card."

Using a prepared script, the caller would tell the beneficiary that their Medicare records were being updated. Once the caller had persuaded the beneficiary to order some or all of this equipment—usually informing the beneficiary that it would be provided at no cost to the beneficiary—the DME telemarketers then called the office of the beneficiary's doctor, stating that the doctor's patient had requested certain equipment and that the DME supplier would be forwarding the doctor a CMN for this equipment. These CMN forms were then forwarded to the doctor's office, with a brief cover letter, referring to their earlier phone conversation. The CMN (including information about the patient's diagnosis) had already been completed by the DME supplier; all the doctor had to do was sign the CMN form and return it to the DME supplier. Once the DME supplier had the CMN in hand, the equipment was delivered to the beneficiary and the DME supplier billed Medicare for the equipment. Although Medicare only pays 80 percent of the cost of DME, beneficiaries were never billed for the remaining 20 percent.

The U.S. Attorney for the Eastern District of Pennsylvania testified at the hearing that his office has brought three cases against DME telemarketing firms, involving a total of 15 defendants. In addition, the offices of the regional Inspector General of HHS and the U.S. Attorney have received over 600 written complaints about abusive telemarketing practices. The U.S. Attorney testified that he believes these abusive practices are continuing and that his office has open files involving 20 DME firms, representing over $25 million in sales to Medicare. Beneficiaries and doctors also complained about the practices of DME telemarketers, suggesting that the Medicare program should prohibit telemarketing of DME. (The Subcommittee requested the opinion of the American Law Division of the Congressional Research Service regarding the power of Congress to ban participation in the Medicare program of DME suppliers who engage in telemarketing. Attachment E is a memorandum prepared by CRS, concluding that a ban on DME telemarketing for Medicare providers would withstand a constitutional challenge.)

Subsequent to the hearing, a Federal grand jury in Pennsylvania returned an indictment charging the operator of a Philadelphia DME supplier with 29 counts of fraud for the submission of false and fraudulent claim forms for items of DME not covered under Medicare. In addition, the U.S. Attorney has filed a civil suit against the DME supplier and its owners, seeking a $5,000 penalty for each false claim submitted by the supplier. Among the allegations in the civil suit is a claim that the DME supplier obtained blank CMN forms already signed by physicians, which the supplier subsequently completed and submitted to the Medicare carrier as if they had been completed by the physician.

Medicare beneficiaries confirmed this pattern of abuse. Beneficiaries related similar stories about how they had been contacted by telephone by representatives from DME suppliers, who gained their confidence by leading them to believe they were representatives from Medicare. The beneficiaries subsequently received a variety of equipment, most often moist heating pads, decubitus care mattresses, sheepskin mattress pads, and TENS units. They did not want and could not use this equipment. Many stated that they never had discussed the need for this equipment with their physi-

cians. The beneficiaries stated that much of the equipment—for which Medicare had paid out thousands of dollars—had never been unpacked and was still in the original boxes. In most instances, the equipment had never been used. Some beneficiaries did not even understand the purpose of some of the equipment, especially TENS units.

Although many beneficiaries contacted the DME suppliers and asked them to take the equipment back, they had to wait substantial periods of time before the equipment was retrieved. A former DME salesman testified that this delay was intentional. Until the equipment was picked up, Medicare continued to pay for the rental of the equipment, up to the maximum allowable rental fee. He also testified that once equipment was returned to the supplier, it was put into a new box and subsequently used again as if it were new. The DME supplier for whom the salesman worked did not have a storefront from which he sold equipment. Rather, his operation was a "boiler room" consisting of a space for the storage of equipment and a series of telephone lines. The business was totally dependent on Medicare. All of its sales were generated by telephone calls to Medicare beneficiaries. Because of the high Medicare reimbursement rates for DME, the company was able to make money even though the Medicare beneficiaries were not billed for their 20-percent share of the DME charges. The salesman also testified that when he delivered equipment, he had routinely presented himself as a representative of Medicare, yelling "Medicare" as he knocked on the door.

A physician testifying at the Subcommittee hearing estimated receiving about 20 CMN forms per month from DME suppliers. He admitted that in the past he had routinely signed them, a practice that he agreed approached negligence. He signed the forms because he assumed that the orders for equipment had originated either with a visiting nurse or with his patients' families, and because he did not want to deprive his patients of equipment that they thought might be useful for untreatable arthritis. He stated that because the name and logo of the Medicare carrier appeared at the top of the CMN form (Attachment F), he thought that the form had been sent to him by Medicare. Not until he was contacted by one of his patients did he realize that the order originated with a DME supplier, rather than with his patient. He also testified that once he discovered the problem, he had a difficult time locating a person at the Medicare carrier who could respond to his complaint. Beneficiaries who received equipment from DME telemarketing firms likewise testified that when they later saw their doctors, they were told that their doctors routinely signed CMNs because they thought that their patients wanted the equipment.

In addition to the problem of high-pressure sales of unnecessary equipment, other abuses involving DME have been identified. The Subcommittee received testimony about instances where DME suppliers changed CMN forms after they had been completed by a doctor, adding equipment not approved by the doctor. The CMN for one beneficiary indicated that she was both bed-confined and room-confined. This was simply false. Not only was the witness able to appear at the hearing, but she also plays an occasional game of tennis.

In addition, the Subcommittee observed serious problems with the quality of many items of DME sold by telemarketers. At the hearing, the Subcommittee observed shoddy equipment which the Medicare program had paid for. Among these were a thin foam rubber pad resembling carpet padding which was billed as a decubitus care mattress, and a wafer-thin flotation pad intended to relieve pain and sores for persons who spend substantial amounts of time sitting. As the salesman testified, abusive DME suppliers are able to maximize their profits by buying shoddy, inexpensive equipment of little therapeutic value, for which the supplier is reimbursed in the same amount as a reputable DME supplier who sells quality equipment.

Processing of DME Claims by Medicare Carriers

When a carrier receives a Medicare claim for an item of durable medical equipment, the claim is processed by a claims examiner to make sure that the claim and the CMN contain all the required information. Information from the claim form is then entered into the carrier's data system. The system performs certain edits to determine the validity of the claim. For example, the system may check to see that items of durable medical equipment are not being ordered with undue frequency. If there is no problem with the claim, it is approved for payment, and a check will be mailed either to the DME supplier or the beneficiary. The Medicare carrier has no way of knowing that the beneficiary actually received the DME listed on the claim form, or of assessing the quality of that equipment. After paying the claim, the carrier sends the beneficiary an Explanation of Medicare Benefits (EOMB), explaining the payment it has made. For DME, this form does not describe the equipment provided to the beneficiary. Medicare beneficiaries who appeared at the hearing presented copies of EOMBs they had received from the Pennsylvania carrier. The EOMBs show only that Medicare has made a payment for a "prosthesis" or "durable equipment." The exact equipment for which Medicare has been billed, however, was not described. Attachment G is an EOMB received by one of the witnesses at the Subcommittee hearing who received a TENS unit. The EOMB only indicates that the beneficiary received a "Supply/Prosthesis (E0730)" for which Medicare paid $335.42.

Special procedures may be followed before Medicare will pay certain types of DME claims. For example, OBRA '90 directed the Secretary of HHS to develop and periodically update a list of equipment that is frequently subject to overutilization. For this equipment, the carriers are directed to determine the medical necessity in advance, i.e., pre-approve an order of DME before a claim is submitted. OBRA '90 specifically states that the list shall include seatlift mechanisms, TENS units, and motorized scooters. The Secretary has not yet added any other items to this list. Although this advance approval provision was made effective for items furnished on or after January 1, 1991, it has been implemented, thus far, only on a pilot basis in Pennsylvania. This pilot program is known as the Medicare Equipment Pre-Approval Program (MEPP). Under this program, if a physician wants to order a TENS unit, motorized

scooter, or seat-lift chair mechanism for a beneficiary in Delaware or in one of five suburban Philadelphia areas, the physician must first contact the carrier by telephone to obtain advance approval for the order. The physician is questioned by a nurse reviewer about the medical necessity for the item. If the request is approved, it is assigned a pre-approval number so that the claim can be paid promptly when it is subsequently submitted.

The MEPP program at Pennsylvania Blue Shield was implemented on March 18, 1991. HCFA has encouraged other carriers to submit plans for similar pre-approval programs involving somewhat different procedures than the MEPP program as implemented at Pennsylvania Blue Shield (e.g., pre-approval by mail rather than by telephone), so that HCFA could evaluate a number of pilot programs before implementing the OBRA '90 pre-approval provisions nationwide. Thus far, no other carrier has implemented a pilot pre-approval program. Carriers have indicated that they did not believe that they received a sufficient number of claims for the three items set forth in OBRA '90 (seat-lift chair mechanisms, TENS units, and motorized scooters) to establish viable pilot programs.

A carrier may implement its own additional screening for DME claims. Pennsylvania Blue Shield, for example, has initiated special procedures for the processing of claims submitted by DME suppliers, about which it has received complaints. For claims submitted by some 18 suppliers alleged to have engaged in fraud or high-pressure sales tactics, 50 percent of the claims are suspended while Pennsylvania Blue Shield investigates the claim. The carrier then contacts the beneficiary and the physician to determine that the equipment shown on the claim was ordered and delivered and that it is medically necessary. Pennsylvania Blue Shield has found that in 30 percent of the cases it has scrutinized under this special project, the equipment had not, in fact, been prescribed by a physician, but rather was added to the claim form after the physician had signed it. In the first seven months of this intensified review, Pennsylvania Blue Shield had examined almost 7,000 claims, and denied claims totaling $455,000.

Payment of DME Claims

The amount that Medicare pays for items of durable medical equipment is determined in accordance with a fee schedule maintained by the carrier. Payment is limited to the lower of the actual charge for the equipment or the fee-schedule amount. There are 55 different fee schedules in effect across the country. A separate schedule is maintained for each of the 55 different localities established by the Secretary.

Prior to passage of OBRA '87, Medicare paid for DME under a reasonable-charge payment system, premised on the principle that Medicare should base its payments on the "going price" in each locality, taking into account all relevant factors in the competitive marketplace. A fee-schedule payment system, effective in 1989, was adopted as part of OBRA '87, which contained a new methodology for determining the amounts Medicare pays for DME. Under the OBRA '87 "six-point plan," DME was divided into six categories: in-

expensive or other routinely purchased durable medical equipment; items requiring frequent and substantial servicing; customized items; capped rental items; oxygen and oxygen equipment; and prosthetics and orthotics. A different method is used to calculate the fee schedule for each category. This six-point plan was further refined in OBRA '90. In OBRA '90, "prosthetics and orthotics" were separated from other DME and subjected to somewhat different rules. The category "prosthetics and orthotics" consists of over 800 items. It includes items that are normally associated with the terms "prosthetics or orthotics," i.e., artificial limbs and supports designed to replace or supplement a body part. It also includes a variety of other types of items, including TENS units, urological supplies, and ostomy supplies. (For purposes of the discussion in this report, however, the Subcommittee intends the term "durable medical equipment" to include prosthetics and orthotics.)

Generally, each carrier must determine the average reasonable charge paid for an item of equipment during some base period, and update this figure by the consumer price index (CPI). For example, the category "inexpensive or routinely purchased DME" is defined as an item (1) the purchase price of which does not exceed $150 or (2) which is acquired by purchase at least 75 percent of the time. This category includes such things as electric heating pads, bed rails, and vaporizers. To determine its 1989 and 1990 fee-schedule allowances for an item in this category, the carrier must compute the average reasonable charge it paid for this item during the period from July 1, 1986, to June 30, 1987. This average charge is then increased by the consumer price index for urban consumers (CPI-U) for the six-month period ending December 31, 1987. For this category of equipment, fee-schedule allowances for 1991 were increased by the 1990 CPI-U, less one percent.

There are variations in the methodology of computing the fee-schedule amounts for each category of DME. For example, for the category "oxygen and oxygen equipment" there is a different base period. The way Medicare carriers compute their fee-schedule amounts for each of the six categories is described in more detail in a Memorandum prepared by the Congressional Research Service (Attachment H).

In 1991 and 1992, national upper and lower limits on fee-schedule allowances are to be phased in. In 1993, these limits, referred to as "floors and ceilings," will be fully phased in and will require carriers with fee-schedule allowances in excess of the ceilings to lower fee-schedule allowances for those items. Carriers with fee-schedule allowances lower than the floor will have to raise fee-schedule allowances for those items. Generally, the ceiling for an item will be equal to the weighted average of local fee-schedule allowances for each item, while the floor will be equal to 85 percent of the weighted average. These floors and ceilings will have the effect of reducing variations among carrier fee schedules to 15 percent. OBRA '90 did not apply the national payment-limit floors and ceilings to prosthetics and orthotics. For these items, regional fee schedules are to be gradually phased in, beginning in 1992.

Even though carriers have begun to phase in national payment limits for their DME fee schedules, Subcommittee staff found substantial variations in fee-schedule allowances among carriers' 1991

DME fee schedules. For example, the carrier in Iowa allows $30.20 for the rental of a nebulizer (used to keep the lungs moist), while the Colorado carrier pays $69.41. In Florida, the carrier pays $19.22 per month for the rental of a humidifier, while the Pennsylvania carrier pays $34.25. A California carrier pays $70.13 for the rental of a home suction pump (used to remove mucous), for which the Colorado carrier pays $35.89. In Florida, rental for an apnea monitor (to monitor breathing during sleep) is reimbursed at the rate of $136.26 per month, while in California the fee-schedule allowance is $230.12. (See Attachment I, comparing prices paid for selected items by five Medicare carriers.) It is these variations in cost which induce DME suppliers to "game the system" by billing the carrier in the service region with the highest reimbursement rate.

Moreover, the cost paid by Medicare for a particular item may bear no relationship to the cost of this item to a supplier. See, for example, Attachment J, prepared by the regional office of the Inspector General of HHS, which compares, for six items of DME, the fee schedules in Maryland, Delaware, New Jersey, New York, and Pennsylvania with the wholesale costs to the supplier for these items. In virtually every instance, the Medicare fee schedule is more than 100 percent of the cost at which a supplier can purchase the item. For some items, the "Medicare mark-up" is more than 1,000 percent. Since January 1, 1991, the Secretary has had the authority to make adjustments (upward or downward) in fee-schedule allowances upon a determination that the otherwise allowed charge is not "inherently reasonable." Under this inherent-reasonableness authority, the Secretary may set special reasonable-charge limits for items of durable medical equipment when the standard rules for determining fee-schedule amounts result in deficient or excessive charges. The Secretary has delegated this inherent reasonableness authority to Medicare carriers, who can make adjustments in their own DME fee schedules when they conclude that their fee-schedule amounts are inappropriate. Pennsylvania Blue Shield testified at the Subcommittee hearing that it has made determinations of inherent-reasonableness with respect to 70 percent of the items of DME. Still, its reimbursement rates rank among the highest in the nation.

FINDINGS AND RECOMMENDATIONS

1. Ban Issuance of Provider Numbers to Durable Medical Equipment Telemarketers

The Subcommittee believes that aggressive telemarketing by DME suppliers has resulted in widespread problems with the Medicare DME benefit. The Subcommittee is concerned that DME telemarketers have misrepresented the DME benefit to Medicare beneficiaries and have created an artificial demand for durable medical equipment. Demand for DME should originate with the beneficiary or with the physician, not with the equipment supplier. The Medicare-eligible population is, the Subcommittee believes, especially vulnerable to abusive telemarketing. By inducing beneficiaries to purchase equipment, telemarketers have replaced physicians as the decision-makers regarding the need for equipment. At the Subcommittee hearing, beneficiaries testified that they were repeatedly

told by telemarketers that the DME offered to them would be provided at no cost to them. Some beneficiaries were led to believe that they were speaking with representatives from the Medicare program.

The Subcommittee believes that applicants for provider numbers as DME suppliers should be queried about their marketing techniques, and those indicating that they intend to seek sales via telephone calls to beneficiaries should be denied a provider number. If an existing DME supplier with a Medicare provider number is found to engage in telemarketing, the Secretary should have the authority to revoke the provider number. The Subcommittee believes that barring Medicare participation by telemarketers will not adversely affect the availability of home medical equipment, and that it will safeguard the integrity of the Medicare program and protect beneficiaries from abusive practices. The Subcommittee is aware of the potential First Amendment problems inherent in the prohibition of telemarketing by DME suppliers who submit claims to the Medicare program, but has relied on the legal opinion of the Congressional Research Service in concluding that such a prohibition could withstand constitutional challenge.

The Subcommittee recommends that Medicare carriers deny Medicare provider numbers to DME suppliers who engage in telemarketing, i.e., suppliers who initiate unsolicited telephone calls to beneficiaries to induce them to buy equipment.

2. Improve oversight of provider numbers and applicants

The Subcommittee is concerned that lack of licensing requirements and lax oversight of the issuance of Medicare provider numbers has allowed unscrupulous DME providers to play a "shell game" with provider numbers. If a carrier becomes concerned about the practices of a supplier and begins subjecting the supplier's claims to intensified scrutiny, the supplier can simply operate under a different provider number and evade this special review. *The Subcommittee recommends that Medicare carriers deny the use of more than one provider number to DME suppliers.*

Furthermore, while the Subcommittee does not believe that licensing or certification requirements should be imposed on DME suppliers, we do believe that carriers should seek additional information about DME suppliers' sales practices which may alert carriers to potential problems. This information would supplement the disclosures regarding ownership and previous Medicare sanctions required of Medicare providers under OBRA '89 (effective January 1, 1992, for new providers, and January 1, 1993, for providers who have previously furnished services). Pennsylvania Blue Shield, for example, has developed a special questionnaire for businesses seeking provider numbers as DME suppliers. The questionnaire asks for such information as the primary items of equipment offered to beneficiaries and the manner in which orders for equipment are received (e.g., by walk-in customers or by telephone). The Subcommittee believes that nationwide use of a similar questionnaire might aid in the early detection of DME fraud. Such a questionnaire should specifically ask whether the supplier intends to engage in telemarketing or door-to-door sales and whether its salespersons are paid on a commission basis, together with any other informa-

tion about sales practices the Secretary believes useful in detecting fraud. *The Subcommittee recommends that HCFA develop a questionnaire (to be completed by DME suppliers applying for Medicare provider numbers) designed to alert Medicare carriers to potentially abusive DME sales practices.*

3. A report on Medicare pre-approval program for overutilized DME

OBRA '90 required that the Secretary develop and periodically update a list of items frequently subject to unnecessary utilization. The law specifically required that seat-lift mechanisms, TENS units, and motorized scooters were to be included in this list. Items on this list were to be subject to a carrier determination "in advance" regarding medical necessity. Thus far, this Medicare Equipment Pre-Approval Program has been implemented on a pilot basis at only one carrier, Pennsylvania Blue Shield, beginning in April, 1991. The Subcommittee believes that there has been sufficient time to make a preliminary assessment of the Medicare Equipment Pre-Approval Program's effectiveness in halting abusive practices in these three items of DME and for evaluating the potential for such programs at other carriers. *The Subcommittee recommends that HCFA submit to the Subcommittee, by January 31, 1992, a report on the Medicare Equipment Pre-Approval Program authorized in OBRA '90.* (This report should include an assessment of the success of the 1991 pilot program, recommendations for improvement and a description of HCFA's plans for implementation of pre-approval programs nationwide.) *The Subcommittee recommends that decubitus care equipment be added to the list of items subject to the pre-approval program.*

4. Rescission of the point-of-sale rules

Under HCFA's point-of-sale regulation, Medicare claims for DME are processed by the carrier responsible for processing claims at the "point-of-sale." In general, the point-of-sale is the place from which the equipment is shipped. This regulation was premised on the idea that a supplier should not receive different reimbursements for the same equipment simply because the beneficiary resides in a different State. The point-of-sale regulation, however, has enabled DME suppliers to manipulate the system by engaging in "carrier shopping." Typically, they will open an office in an area with high reimbursement rates and ship all their equipment, including out-of-state orders, from that facility. This enables them to take advantage of the high fee schedule allowances in the State from which their equipment is shipped. The point-of-sale regulation also enables suppliers to circumvent coverage criteria that a carrier has established. For example, the Colorado carrier has established a limit on the amount of ostomy supplies for which it will pay during a year on behalf of a single beneficiary. The carrier suspects that suppliers avoid this limit simply by shipping additional supplies (in excess of the Colorado limit) from a facility outside Colorado. These suppliers then bill other carriers who have not established limits like those applied in Colorado. The current process makes it possible for suppliers to take advantage of disparate fee schedules and coverage policies. *The Subcommittee recommends that, in order to prevent "carrier shopping," carriers reimburse*

DME suppliers based on the fee schedule in effect for the residence or address of the beneficiary, rather than the fee schedule at the "point-of-sale."

5. Replacement of Certificate of Medical Necessity (CMN) forms with a standardized Physician's Prescription form

The Subcommittee is concerned that DME suppliers have controlled the ordering of DME. In the past, DME suppliers submitted completed CMNs to physicians, who merely had to sign them and return them to the supplier before a claim could be submitted for an item of DME. The Congress intended physicians to be the "gatekeepers" responsible for determining their patients' need for equipment. In many instances, however, the physician's only role has been to affix his or her signature to a pre-completed form and return it to the DME supplier, who files it with the Medicare carrier along with the claim form. Physicians really have no incentive to be careful or accurate in their approval of orders for DME. The Subcommittee believes, however, that orders for DME should be physician-driven, and that it is important that physicians appreciate the seriousness of their roles in ordering DME.

When fully implemented, the OBRA '90 prohibition against the submission to physicians by DME suppliers of pre-completed forms should help achieve this goal. The Subcommittee believes, however, that additional steps should be taken to assure that physicians are overseeing orders for DME. The Subcommittee believes that this could be achieved in large part by improvements in the CMN form. Currently, while HCFA has developed a standardized form for oxygen equipment, each carrier has been charged with the responsibility of developing its own forms for other items of DME. *The Subcommittee recommends that HCFA develop a standardized "Physician's Prescription for Durable Medical Equipment" to be used nationwide, containing information both from the supplier and the physician.*

Although designated a "prescription," the Subcommittee does not intend that this form must originate with a physician in every instance. The Subcommittee does not intend to preclude a Medicare beneficiary from selecting an item of DME from a supplier. We believe it is entirely appropriate, for example, for a beneficiary to select a cane or walker from a DME supplier. Accordingly, in these instances, the prescription form may originate with a supplier, to be forwarded to the prescribing physician, who, upon completion of the form, will return it to the supplier, to be filed along with the Part B claim.

Further, the Subcommittee does not intend to propose an all-inclusive list of information to be sought on the prescription form. The Subcommittee recommends, however, that the form include a check-off box to indicate whether the physician has spoken to his patient about the equipment or indicate the date on which the physician last examined the patient. In addition, the form should contain a telephone number that the physician can call if there are complaints or questions. Lastly, the form should contain a warning to physicians about the willful approval of unnecessary equipment.

The Subcommittee does not intend that the present-law rule be changed to prohibit the supplier from completing the physician's

portion of the form. A part of the form, however, should be reserved for the supplier. This part of the form should reflect the price the supplier intends to charge, including the amount that the supplier intends to charge the beneficiary. If the supplier intends to waive the beneficiary's copayment, this fact should be reflected on the form, along with a warning reflecting HCFA's policy against the routine waiver of copayments.

The Subcommittee also believes that it would be beneficial for the beneficiary to receive a copy of the completed prescription form. The information on this form will allow the beneficiary to serve as a check on the integrity of the system. The beneficiary will be able to make sure that the equipment listed on the form is the equipment discussed with his or her physician. A statement showing the price to be charged to the beneficiary may cause the physician and the beneficiary to pay closer attention to the necessity of the items. *The Subcommittee recommends that DME suppliers be required to deliver a copy of the completed Physician's Prescription for Durable Medical Equipment form to the beneficiary.*

For equipment that poses special problems (e.g., TENS units and seat-lift chair mechanisms), some carriers have developed specialized forms. These forms include specific questions that the carriers have found useful in evaluating the medical necessity of the equipment. The Subcommittee believes that HCFA should review these carrier efforts. *The Subcommittee recommends that HCFA develop equipment-specific standardized forms for items of DME subject to abusive practices.*

6. Improve Beneficiary Understanding of the DME Benefit By a More Explicit Explanation of Medical Benefits

The Subcommittee believes that it is crucial that beneficiaries participate in decisions involving DME orders and understand the Medicare DME benefit. One of the tactics used by unscrupulous suppliers of durable medical equipment is the routine waiver of the 20-percent copayment due from beneficiaries. This copayment serves as a form of insurance that beneficiaries will not obtain unnecessary equipment and that they will not obtain equipment of poor quality. Beneficiaries who have to pay a portion of the bill for DME are unlikely to order equipment that they will not use or to accept substandard equipment.

The Medicare laws provide for 80 percent reimbursement for purchases or rentals of DME. Under HCFA policy guidelines, waivers of the 20-percent copayment are permitted only when a supplier has determined that a beneficiary is indigent or when the amount due from a beneficiary is less than the costs of billing or collection. When a supplier has no intention of collecting the 20-percent copayment from the beneficiary, then the true amount of the supplier's charge is actually 20 percent less than the amount shown on the Medicare claim. Accordingly, a DME supplier that routinely waives Medicare copayments is misstating the charge to beneficiaries, and the Inspector General has determined that such routine waivers may violate the False Claims Act. In addition, the Inspector General has also taken the position that when a supplier routinely waives a copayment, the supplier may also be paying something of value (i.e., the amount of the copayment due from the

beneficiary) as an inducement to generate business payable by Medicare, in violation of the anti-kickback statute. The Subcommittee supports the efforts undertaken by carriers and the Inspector General of HHS to alert beneficiaries to the problem of routine waivers of copayments.

Beneficiaries can serve as a check on the correctness of DME claims. The Subcommittee received testimony about instances where DME suppliers, after receiving a CMN signed by a physician, had added to the CMN additional equipment not approved by the physician and had submitted claims for this additional equipment to the Medicare carrier. In addition, there are instances where the supplier may deliver one item to the beneficiary and bill Medicare for a different (more expensive) item. Ideally, the Explanation of Medical Benefits beneficiaries receive should alert them to such inconsistencies. Beneficiaries often are not able to interpret the Explanation, as the equipment Medicare has paid for is described only by an alpha-numeric code. For example, a beneficiary who has received a gel pressure mattress has no way of assuring that this is what Medicare has actually paid for when the Explanation simply reflects that a payment was made for "1 Durable Equipment EO196." *The Subcommittee recommends that Medicare carriers amend the Explanation of Medical Benefits form so that beneficiaries can clearly understand exactly what equipment has been paid for by Medicare.*

7. Monitor the quality of DME

The Subcommittee is concerned about the quality of DME provided to Medicare beneficiaries. At the hearing, Subcommittee Members saw examples of poor quality DME. These included a wheelchair cushion so thin as to be of virtually no value, and a foam pad which a supplier claimed to be a decubitus care mattress and which had, although never used, fallen apart. The Subcommittee believes that the most effective way to insure that equipment is of high quality is to ensure that DME suppliers do not waive the 20-percent copayment due from beneficiaries. Beneficiaries will not pay with their own funds for substandard equipment.

The Subcommittee also believes that the poor quality of some equipment is attributable to the fact that the HCFA does not establish any standards or definitions for DME. Medicare fee schedules do not differentiate, for example, among wheelchair flotation pads. The carrier pays the same fee-schedule allowance whether the flotation pad is of high quality or useless. While the Subcommittee believes it would be burdensome to set forth design specifications or standards for each of the 266 items of DME and 824 prosthetic and orthotic items, the Subcommittee believes that minimum standards or definitions are appropriate for items about which there have been a substantial number of complaints regarding quality. *The Subcommittee recommends that by September 1, 1992, HCFA prepare a list of items of DME for which improved definitions or standards might be appropriate, together with recommendations regarding quality standards and definitional terms.* (In preparing this list, HCFA should consult with the HHS Inspector General, DME manufacturers, and industry standard-setting groups regarding proposed quality standards.)

8. Improved "Inherent Reasonableness" Authority to Determine Fairness of DME Fee Schedules

Since January 1, 1991, the Secretary has had the authority to adjust fee-schedule allowances for items that are not "inherently reasonable," i.e., excessively over- or under-priced. The Secretary has delegated this inherent reasonableness authority for DME to carriers. Carriers, however, complained that because fee-schedule allowances are determined based on prices paid during an earlier base period, they must look at outdated information pertaining to those earlier years to determine whether the fee-schedule allowances are reasonable. For example, fee-schedule allowances for the category of DME known as "inexpensive or routinely purchased items of DME" are based on the prices the carriers paid during the base period June 1, 1986, to June 30, 1987. In determining the reasonableness of the fee-schedule allowances for this category, carriers compare their fee schedules with DME price information (e.g., wholesale price lists) for the earlier years. Carriers indicated that they could make more accurate inherent-reasonableness determinations if they use current price information in assessing inherent reasonableness.

The Subcommittee recommends that Medicare carriers use current price information, including current wholesale prices, in making determinations regarding the inherent reasonableness of DME fee schedule allowances. The Subcommittee recommends that carriers immediately undertake inherent-reasonableness determinations for at least five items of DME believed to be overpriced or overutilized, including decubitus care equipment, TENS units, and other items selected by the Secretary.

9. Comptroller General study regarding a national DME fee schedule

The Subcommittee is concerned that in many cases DME prices are excessive, and that these excessive prices have encouraged fraud and abuse. On the other hand, suppliers have complained that in some instances fee-schedule allowances are insufficient to cover their costs. Fee-schedule allowances are, for the most part, based on the average price paid by Medicare during some base period. These average prices, however, may bear no relationship to the actual cost of an item. At the hearing, for example, the Subcommittee saw instances where Medicare paid up to $240.96 for a wheelchair flotation pad, where the wholesale cost to the supplier for this item was $23.49. For an electric heating pad, costing a supplier $9.68, Medicare paid up to $66.29.

In addition, the Subcommittee is concerned about variations in local fee-schedule allowances. These fee-schedule differentials will shrink to 15 percent when the DME fee schedules are fully phased in, in 1993. Still, the differences in fee-schedule allowances may bear no relationship to local cost differentials, but simply reflect historical charges paid by local carriers. Moreover, the high average costs paid by some carriers will have the effect of raising low fee-schedule allowances established by other carriers.

The Subcommittee believes that many items of DME are sold on a nationwide market. For these items, the Subcommittee believes

that consideration should be given to the adoption of a national fee schedule for DME. Part of the price of many items of DME, however, is a service component. In addition, local delivery and labor costs may affect the costs of some items.

H.R. 1555, making technical corrections in the Revenue Reconciliation Act of 1990, includes two reports pertaining to durable medical equipment. The bill would direct HCFA to collect data on supplier costs of DME and to analyze the data to determine the proportions of the costs attributable to service and product components of furnishing such equipment. With this data, HCFA would make recommendations for a geographic cost-adjustment index for DME suppliers and to analyze the impact of the proposed index on payments under the medicare program. In addition, H.R. 1555 calls for a report by the Comptroller General analyzing, on a geographic basis, the supplier costs of DME. This report would be due as of July 1, 1992. *The Subcommittee recommends that the report of the Comptroller General, as proposed in H.R. 1555, be expanded to include, for 150 items of DME, a comparison of supplier costs with the range of fee-schedule allowances for these items, an analysis of the fairness of a national fee schedule for DME, and a proposed timetable for implementation of a nationwide fee schedule for those items, or classes of items, for which nationwide fee schedules would be appropriate.*

10. Reclassification of certain items of DME

OBRA '90 reformed the rules regarding reimbursement for prosthetics and orthotics (a category which includes TENS units) and other DME. A prosthetic device is an artificial substitute or replacement for a missing part of the body. An orthotic is a support or brace for a weak or ineffectual body part. True prosthetics and orthotics may require substantial and skilled customized design and fitting. Many of the items classified as "prosthetics and orthotics," for purposes of Medicare, fall outside the normal understanding of those terms and do not require the special expertise of a prosthetist or an orthotist. TENS units, for example, are classified as prosthetics and orthotics. Urological and ostomy supplies, which are widely available at medical supply businesses, are also classified as prosthetics and orthotics.

For DME, there is a separate fee schedule for each carrier service area, subject to national floors and ceilings, which will ultimately reduce to 15 percent the variations among fee-schedule allowances for DME. By contrast, beginning in 1992, carriers will reimburse suppliers for prosthetics and orthotics in accordance with regional (rather than national) fee schedules. Moreover, there are regional, rather than national, floors and ceilings with respect to prosthetics and orthotics. Accordingly, the fee-schedule allowances for prosthetics and orthotics may fluctuate widely among regions across the country.

The Subcommittee sees no reason why these types of items should be subject to widely varying fee schedules and not subject to national payment limits (i.e., floors and ceilings). National payment limits have the effect of evening out fee schedules and lowering allowances for items that are substantially overpriced (while perhaps raising allowances for areas where reimbursement rates are unre-

alistically low). Accordingly, *the Subcommittee recommends that by December 31, 1992, HCFA review the items classified as prosthetics and orthotics to identify those items that do not require individualized, custom fitting and adjustment, and submit recommendations regarding the appropriate method for reimbursement of these items similar to other classes of DME.*

ATTACHMENT A

ITEM (A)	SUPPLIER'S COST (B)	AMOUNT BILLED TO MEDICARE (C)	AMOUNT PAID BY MEDICARE (D)
Commode Chair	$28.00	$195.00 Sale $50.00 Rent	$84.50 Sale $22.83 Rent
Decubitus Care Mattress	$40.00	$700.00 Sale $100.00 Rent	$434.95 Sale $48.41 Rent
Flotation Pad (Wheelchair Cushion)	$8.00	$385.00 Sale $85.00 Rent	$348.96 Sale $59.20 Rent
Moist Electric Heating Pad	$7.97	$75.00 Sale	$53.00 Sale
Total Electric Hospital Bed	$647.00	$3,100.00 Sale $260.00 Rent	$1,632.70 Sale $160.00 Rent
Knee Brace (1)	$23.83	$125.00 Sale	$59.17 Sale
Knee Brace (2)	$12.40	$75.00 Sale	$53.38 Sale
Lumbo-Spiral Orthosis Back Brace	$19.10	$130.00 Sale	$71.52 Sale
Paraffin Wax Bath	$78.95	$250.00 Sale $60.00 Rent	$183.22 Sale $34.58 Rent
4-Lead Tens Unit	$49.90	$750.00 Sale $150.00 Rent	$452.00 Sale $58.46 Rent
Lightweight Wheelchair	$256.00	$1,800.00 Sale $175.00 Rent	$864.59 Sale $70.18 Rent
Various Cases			
Seat Lift Chair	$280.00	$949.00	$882.00 (QCH)
TENS	$83.00	$650.00-$700.00	$472.83 (SL)
Catheter Care Kit (Tovolette, Sponge, Plastic Bag, Gloves)	$0.46	$3.60	Uncertain (WGD)
Ostomy Supplies (3 Boxes Stoma Adhesive Wafers --Plus 1 Box of Ostomy Pouches	$84.00 $58.26	$264.00	$272.39
Home Infusion Therapy Products			
Chemotherapy Solution for Some Cancers (5 Doses)	$3.95	$1,185.00-$2,000.00	Unknown
TPM Solution (1 1/2 Liters)	$50.00	$300.00-$687.00	Unknown
Antibiotic Solution (2 Grams)	$24.00	$185.00-$200.00	Unknown

Pennsylvania
Blue Shield

Camp Hill
Pennsylvania 17089

ATTACHMENT B

PENNSYLVANIA BLUE SHIELD
MEDICARE PART B
DURABLE MEDICAL EQUIPMENT/SUPPLIER QUESTIONNAIRE

1. Name of Company _____

2. Business Address _____
_____
_____ Telephone _____

3. Mailing Address _____
_____
_____ Telephone _____

4. What type of business is this? (Please check)
Sole Proprietor _____ Partnership _____ Corporation _____

5. Please list the complete address and telephone numbers of any other offices and locations, including field or sales offices, that your company uses or maintains.
_____
_____
_____
_____

6. Please list any other Medicare carriers that you bill, in addition to Pennsylvania Blue Shield, for any services provided at any of your locations. Include the name of each Medicare carrier, the provider numbers they have assigned you, and the primary items for which you bill them.
_____
_____
_____
_____

7. Please list the primary items of durable medical equipment and supplies which you offer to Medicare beneficiaries.

8. Please describe in detail how these items are marketed, by whom and to whom. For example, are physicians, nurses, therapists or beneficiaries used for this purpose? Do these procedures vary by the type of item? If so, please describe.

9. Please describe in detail how orders for these items are received and processed? For example, are they received by telephone or in person? Are items ordered by the Medicare beneficiary or the prescribing physician? Is equipment mailed, delivered to, or picked up by the beneficiary? Do these procedures vary by type of item? If so, please describe.

10. How are prescribing physician and beneficiary signatures obtained?

11. Please list the name, specialty and license number of any physician, respiratory therapist, and/or other licensed practitioner who is an employee, officer, or who has an ownership interest in your company, and specify his or her exact function.

12 Please list the name, specialty and license number of any physician, respiratory therapist, and/or other certified practitioner who is used on a consulting/contract basis, and specify his or her exact function.

13 If your company uses any outside billing service for claims preparation and filing, please list the complete name and address of each company that provides these services for you.

14 If your company is related to any other organization or any individual who is or has been a provider of Medicare services, please identify the organization(s), their relationship to your company, and indicate the nature of the Medicare services they provide. Indicate also the names of the Medicare contractors that are billed by the organization or individual and the provider numbers used for this purpose.

15 Please list the names of each owner, partner, or other individual who has a financial interest in your company, indicating whether that individual is an owner or a partner, or the exact nature of the financial interest.

16 Have you, any of your employees, or any of the individuals listed above been the subject of any civil or criminal action with respect to services billed to Medicare, Medicaid, or any other insurance company? If yes, please provide details below.

When completed and signed, this questionnaire should be returned to the following address:

Provider Information Management
Pennsylvania Blue Shield
P.O. Box 898842
Camp Hill, PA 17089-8842
Attention: Dianna DeLancey

PLEASE INCLUDE COPIES OF THE FOLLOWING DOCUMENTS

- Articles of Incorporation
- Financial Statement to date (if appropriate) or the last full year of operation
- Federal Tax Identification Number (either Social Security card or notice of new Employer Identification Number assigned)

I certify that the information contained herein is, to the best of my knowledge, complete and accurate. I understand that any intentional misrepresentation or falsification of essential information to receive payment of Federal and/or State funds may be subject to prosecution under applicable Federal and/or State laws, and/or imposition of Civil Money Penalties by the Federal Government. I further agree to advise Pennsylvania Blue Shield of changes that subsequently occur with respect to any of the information provided herein.

_____
Name of President or CEO

_____ _____
Signature (President or CEO) Date

_____ _____
Witness Date

SWORN & subscribed before me this _____ day of _____ 19____

_____
NOTARY PUBLIC

MY COMMISSION EXPIRES _____

ATTACHMENT C

Medicare

Contractor for Medicare - Blue Cross and Blue Shield of Colorado
Part B
700 Broadway, Denver, Colorado 80273-0002

Certification For Durable Medical Equipment

☐ New ☐ Recertification

PHYSICIAN — Medicare regulations require the following to qualify your patients for Medicare benefits on durable medical equipment.

PATIENT NAME | HEALTH INSURANCE CLAIM NUMBER

ADDRESS (Street, City, State, Zip Code)

Is patient in nursing home? ☐ Yes ☐ No If "Yes," From Month Day Year To Month Day Year

PERIOD OF MEDICAL NECESSITY (Number of months) | DIAGNOSIS | PROGNOSIS

IF EQUIPMENT IS AMBULATORY	HCPC CODE	ANSWER QUESTIONS
☐ Cane, Crutches, Walker		1 and 2
☐ Wheelchair		1 and 3
☐ Motorized Wheelchair		Use Form #94403
☐ Special Wheelchair		3 and 19
DECUBITUS CARE		
☐ Decubitus Care		3, 16, and 17
REPAIRS AND REPLACEMENT PARTS		
☐ Repairs ☐ Replacement Parts		12, 23, and questions necessary to certify equipment
TRACTION, ORTHOPEDIC		
☐ Traction and Fracture Frame		15
☐ Continuous Positive Motion Device		26
☐ Heat application		16 and 18
HYGIENE		
☐ Commode		3, 4, and 5
☐ Bed pan/Urinal		3
☐ Sitz Bath		18

IF EQUIPMENT IS HOSPITAL BED AND ACCESSORIES	HCPC CODE	ANSWER QUESTIONS
☐ Standard Hospital Bed		6 and 8
☐ Variable Height Hospital Bed		6, 8, 14, and 18
☐ Electric Hospital Bed		6, 8, 9, 10, and 18
☐ Mattress		12, and 13
☐ Siderails		11, 12, and 13
☐ Trapeze Bar		3, 7, and 14
PUMPS		
☐ Pneumatic Pump		18, 19, and 27
☐ Infusion Pump		20
MONITORS		
☐ Blood Glucose Monitors		19, 21, and 22
☐ Nasal CPAP		18, 24, and 25
SEAT/PATIENT LIFTS		Use Form #94372
OTHER (Please specify)		18

ANSWER ALL QUESTIONS APPLICABLE TO EQUIPMENT

1. Is patient ambulatory? ☐ Yes ☐ No
2. Is ambulation impaired? ☐ Yes ☐ No
3. Is patient bed or chair confined? ☐ Yes ☐ No
4. Is patient room confined? ☐ Yes ☐ No
5. Is patient confined to an area without a bathroom? ☐ Yes ☐ No
6. Is body positioning required that would not be feasible in ordinary bed? ☐ Yes ☐ No If "Yes," please explain
7. Does patient need to sit up due to respiratory condition or change body positions for other medical reasons? ☐ Yes ☐ No
8. Does patient condition require special attachments that cannot be fixed to a standard bed? ☐ Yes ☐ No
   List attachments:
9. Does patient condition require frequent and/or immediate changes in body positions? ☐ Yes ☐ No
10. Can patient operate controls? ☐ Yes ☐ No
11. Are siderails an integral part of hospital bed? ☐ Yes ☐ No
12. Does patient own equipment? ☐ Yes ☐ No
13. Are mattress/siderails being used with prescribed hospital bed? ☐ Yes ☐ No
14. Does patient need equipment to get in or out of bed or to assist in transfer from bed to wheelchair? ☐ Yes ☐ No
15. Does patient have an orthopedic impairment requiring traction equipment which prevents ambulation during period of use? ☐ Yes ☐ No
16. Has item been prescribed as part of a planned regimen of treatment in patient home? ☐ Yes ☐ No
17. Is patient highly susceptible to decubitus ulcers? ☐ Yes ☐ No
18. Describe in Special Item section how equipment is therapeutically beneficial to patient treatment program or is necessary for patient condition.
19. Has patient or caregiver been instructed in use of equipment? ☐ Yes ☐ No
20. What drugs or chemical agents are being administered with infusion pump?
21. Is patient insulin treated? ☐ Yes ☐ No
22. Does patient have poor diabetic control? ☐ Yes ☐ No
    If "Yes," please explain:
23. Describe or provide an HCPCS code for the item being repaired.
24. Does a 6-7 hour nocturnal study document 30 episodes of apnea each lasting more than 10 seconds? ☐ Yes ☐ No
25. Without this equipment, would the patient require surgery? ☐ Yes ☐ No
26. Has patient had a total knee replacement? ☐ Yes ☐ No
    Surgery date:
    Date patient began using CPM:
27. Does patient have intractable lymphedema of the extremities? ☐ Yes ☐ No

SPECIAL FEATURE ITEM

GIVE COMPLETE DETAILED EXPLANATION FOR THE MEDICAL NECESSITY OF ITEMS

PHYSICIAN NAME (PLEASE PRINT) | TELEPHONE NUMBER | PHYSICIAN MEDICARE # - MSP #

DATE

Medicare

Carriers for Medicare: Blue Cross and Blue Shield of Colorado
Form B

Certificate of Medical Necessity for Wheelchair

PATIENT NAME | HEALTH INSURANCE CLAIM NUMBER

PRESCRIBED EQUIPMENT

- ☐ E1210 — Motorized wheelchair, with microswitch control, fixed full-length arms, swing away detachable elevating legrests
- ☐ E1211 — Motorized wheelchair, with microswitch control, detachable arms, desk or full-length swing away, detachable elevating legrest
- ☐ E1212 — Motorized wheelchair, with microswitch control, fixed full-length arms, swing away detachable footrests
- ☐ E1213 — Motorized wheelchair, with microswitch control, detachable arms, desk or full length, swing away detachable footrests
- ☐ E1230 — Power operated vehicle (three wheel, non-highway), indicate brand name and model number _____
- ☐ ( ) — Other — describe: _____

PATIENT AGE | PROGNOSIS

ESTIMATED LIFE SPAN | ESTIMATED DURATION OF NEED

DIAGNOSIS AND SECONDARY DIAGNOSIS (EXPLAIN IN DETAIL)

WHAT, IF ANY, CARDIAC AND/OR PULMONARY DISEASE CONDITIONS EXIST IN THIS PATIENT?

TO WHAT DEGREE IS PATIENT'S VISUAL ACUITY IMPAIRED?

TO WHAT DEGREE IS THERE LOSS OF MOTOR FUNCTION IN THE LOWER EXTREMITIES? IS PATIENT ABLE TO AMBULATE? AND IF SO, HOW FAR AND WITH WHAT DEGREE OF ASSISTANCE? EXPLAIN:

TO WHAT DEGREE IS THERE LOSS OF MOTOR FUNCTION IN THE UPPER EXTREMITIES? (EXPLAIN)

CAN PATIENT OPERATE CONTROLS?
- ☐ Yes
- ☐ No

PATIENT LIVING CONDITIONS — DOES PATIENT LIVE IN NURSING HOME OR SENIORS' HOME? WHO TAKES CARE OF PATIENT? WHAT KIND OF CARE DOES PATIENT NEED AND DOES PATIENT LIVE ALONE? WHAT LIMITATIONS DOES CAREGIVER HAVE?

TO WHAT EXTENT AND WHEN WILL WHEELCHAIR BE USED?

DID PATIENT HAVE AN OPERABLE WHEELCHAIR PRIOR TO THIS REQUEST? ☐ Yes ☐ No

WHAT TYPE OF WHEELCHAIR DID PATIENT HAVE PREVIOUSLY?

DOES THE SEATING CONFIGURATION ON THE PRESCRIBED CHAIR PROVIDE ADEQUATE SUPPORT FOR LONG TERM USE?

ARE YOU THE ATTENDING PHYSICIAN? ☐ YES ☐ NO IF YES, WHEN DID YOU LAST SEE THIS PATIENT?

I, the undersigned, certify that the above-prescribed durable medical equipment is medically necessary as part of my treatment program for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience" equipment.

PRESCRIBING PHYSICIAN SIGNATURE | DATE SIGNED

TYPE OR PRINT PHYSICIAN NAME | PHYSICIAN MEDICARE I.D. NUMBER | TELEPHONE NUMBER

PHYSICIAN SPECIALTY | PHYSICIAN SUBSPECIALTY

Medicare

Carrier for Medicare: Blue Cross and Blue Shield of Colorado
Part B

Certification for TNS/NMES

Medicare requires that medical necessity be certified by the patient's physician. The Medicare program will consider coverage of TNS for acute post-operative and chronic intractable pain. NMES is a covered Medicare expense for disuse atrophy when the nerve supply is intact. We need information from you to assess the severity of the patient's condition and to determine if the Medicare criteria for coverage are met. Claims for electronic stimulation devices cannot be paid without this documentation.

PATIENT NAME | HEALTH INSURANCE CLAIM NUMBER

ADDRESS (Street, City, State, Zip Code)

Is patient in nursing home? ☐ Yes ☐ No — If "Yes," From (Month / Day / Year) To (Month / Day / Year)

PERIOD OF MEDICAL NECESSITY (Number of months) | DIAGNOSIS | PROGNOSIS

EQUIPMENT

☐ E0720 TNS, 2 lead, localized stimulation
☐ E0740 TNS, 4 lead, larger area/multiple nerves
☐ Y3345 TNS rental (one month trial)
☐ Y3346 TNS, rental (second month trial)
☐ E0744 Neuromuscular stimulator for scoliosis
☐ E0745 Neuromuscular stimulator

ARE YOU THE PATIENT'S ATTENDING PHYSICIAN? ☐ YES ☐ NO | IF YOU ARE NOT THE ATTENDING PHYSICIAN, EXPLAIN YOUR INVOLVEMENT WITH THE PATIENT | DATE OF INITIAL EXAMINATION

FULLY DESCRIBE THE CONDITION AND DIAGNOSIS THAT NECESSITATE A TNS OR NMES

HOW LONG HAVE YOU BEEN TREATING THE PATIENT FOR THIS DIAGNOSIS? | DATE LAST SEEN FOR THIS DIAGNOSIS

IF A 4 LEAD TNS IS REQUIRED, PLEASE EXPLAIN WHY

DOES THE PATIENT HAVE ANY CONDITION OR HAVE ANY IMPLANTS, SUCH AS A PACEMAKER WHICH, IN YOUR OPINION, WOULD CONTRAINDICATE THE USE OF THE EQUIPMENT? ☐ YES ☐ NO
Explain:

WAS THE TNS UNIT PRESCRIBED FOR ACUTE POST OPERATIVE PAIN? ☐ YES ☐ NO | WAS THE NMES UNIT PRESCRIBED FOR POST-OPERATIVE DISUSE ATROPHY ☐ YES ☐ NO

IF YES, WHAT SURGICAL PROCEDURE WAS PERFORMED? | IF APPLICABLE, WAS SURGERY PERFORMED ON AN INPATIENT OR OUTPATIENT BASIS? | DATE OF SURGERY

HOW LONG HAS THE PATIENT EXPERIENCED CHRONIC INTRACTABLE PAIN? (TNS) | WHERE IS PAIN LOCATED? | WHAT COURSE OF TREATMENT OR THERAPY WAS USED TO ALLEVIATE PAIN PRIOR TO USING TNS?

HOW LONG HAS THE PATIENT EXPERIENCED DISUSE ATROPHY? (NMES) LIST AFFECTED MUSCLE GROUPS | WHAT COURSE OF TREATMENT OR THERAPY IS BEING USED TO RESTORE FUNCTION IN ADDITION TO NMES?

WHAT ARE THE RESULTS OF OTHER TREATMENT / THERAPY?

DESCRIBE HOW THE PRESCRIBED TNS / NMES WOULD BE USED IN YOUR TREATMENT PLAN

WHAT SIGNIFICANT THERAPEUTIC BENEFIT WILL THE PATIENT DERIVE FROM USE OF TNS / NMES? EXPLAIN

ANSWER IF PRESCRIBING THE RENTAL OF TNS FOR A SECOND TRIAL MONTH

PROVIDE DATES THAT THE PATIENT WAS EVALUATED DURING THE FIRST TRIAL MONTH | NOTE YOUR FINDINGS RELATED TO THE EFFECTIVENESS OF THE TNS UNIT IN MODULATING PAIN

WHY IS AN ADDITIONAL TRIAL MONTH NECESSARY?

ANSWER THE FOLLOWING QUESTIONS IF PRESCRIBING THE PURCHASE OF A TNS UNIT

Was the unit used on a trial basis for effectiveness in modulating pain? ☐ Yes ☐ No | If Yes, on what dates was a TNS unit used for a trial period? First date _____ Last date _____

WHAT IF ANY BENEFIT WAS REALIZED FROM USING THE TNS DURING THE TRIAL PERIOD?

PROVIDE THE DATES PATIENT WAS EVALUATED TO DETERMINE THE EFFECTIVENESS OF THE TNS

IF A PHYSICAL THERAPIST SUPERVISED THE PATIENT'S TRIAL PERIOD, WHAT WAS THE MOST RECENT DATE THAT THE PHYSICAL THERAPIST NOTIFIED YOU OF THE PATIENT'S PROGRESS?

Has the patient been trained in the self-use to the TNS? ☐ Yes ☐ No | What significant therapeutic benefit will the patient derive from continued use of the TNS? Explain:

Do you have a financial interest in or a contractual relationship with the supplier of the TNS/NMES? ☐ Yes ☐ No
Explain:

I, the undersigned, certify that the above prescribed equipment is medically necessary as part of my treatment program for this patient. In my opinion, the equipment prescribed is reasonable and necessary for treatment of this patient's condition and has not been prescribed as convenience equipment. I further certify that all the responses contained herein are accurate.

PHYSICIAN NAME AND ADDRESS (Please Print) | TELEPHONE NUMBER | PHYSICIAN MEDICARE NUMBER

PHYSICIAN SIGNATURE | PHYSICIAN SPECIALTY | DATE

FORM NO. 99099

WHITE - Medicare — CANARY - Carrier — PINK - Physician

CONTRACTOR FOR
MEDICARE
Blue Cross and Blue Shield of Colorado
700 Broadway
Denver, Colorado 80273
(303) 831-2081
Toll Free: 1-800-332-6081

Certificate of Medical Necessity For Patient or Seat Lifts

PATIENT NAME | HEALTH INSURANCE CLAIM NUMBER

PRESCRIBED EQUIPMENT

- ☐ Seat Lift e.g. easy lift chair (E0620)
- ☐ Sling or Seat for Patient Lift (E0621)
- ☐ Patient Lift, Cantop, Bathtub or Toilet Lift (E0625)
- ☐ Hydraulic Patient Lift with Seat (E0630)
- ☐ Electric Patient Lift with Seat or Sling (E0635)

PATIENT AGE | PROGNOSIS

ESTIMATED LIFE SPAN | ESTIMATED DURATION OF MEDICAL NEED

IDENTIFY CONDITION(S) FOR WHICH YOU ARE TREATING PATIENT — INCLUDE ALL DIAGNOSIS AND SPECIFIC WEAKNESSES AND IMPAIRMENTS

WHAT IS THE SEVERITY OF THE PATIENT'S CONDITION? HOW LONG HAS THIS BEEN THE STATUS?

WHAT TREATMENT/THERAPY HAS BEEN PROVIDED TO ENABLE THE PATIENT TO ATTAIN A STANDING POSTURE AND OR IMPROVE THE ABILITY TO AMBULATE?

TO WHAT DEGREE CAN PATIENT USE HIS/ HER UPPER EXTREMITIES TO ASSIST IN TRANSFERS AND GETTING OUT OF A CHAIR? PLEASE INDICATE PERCENTAGE OF EXTREMITY LOSS.

WHAT DISTANCE IS PATIENT ABLE TO WALK AFTER GETTING UP FROM THE CHAIR? WHAT TYPE OF ASSISTANCE IS REQUIRED?

DOES PATIENT HAVE A WHEELCHAIR? ☐ YES ☐ NO? TO WHAT EXTENT IS WHEELCHAIR USED?

INDICATE PERCENTAGE OF LOWER EXTREMITY LOSS

CAN PATIENT TRANSFER INDEPENDENTLY OR DOES HE/SHE NEED ASSISTANCE? WHAT KIND OF ASSISTANCE IS NEEDED (MANUAL OR MECHANICAL)?

WHAT IS CURRENT LIVING SITUATION OF THE PATIENT AND WHO CARES FOR HIM/ HER? CAN ATTENDANT/S ASSIST PATIENT IN TRANSFERS AND REPOSITIONING, ETC. AND IF NOT, WHY? CAN PATIENT OPERATE LIFT?

EXPLAIN MEDICAL NECESSITY FOR THIS DURABLE MEDICAL EQUIPMENT

HOW IS EQUIPMENT THERAPEUTICALLY BENEFICIAL?

HOW IS EQUIPMENT PART OF THE PATIENT'S TREATMENT REGIMEN?

ARE YOU THE ATTENDING PHYSICIAN? ☐ YES ☐ NO IF "YES," WHEN DID YOU LAST SEE THIS PATIENT? HOW OFTEN DO YOU SEE THIS PATIENT?

, the undersigned, certify that the above-prescribed durable medical equipment is medically necessary as part of my treatment program for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience" equipment.

understand that intentional misrepresentation of diagnoses, services, or medical necessity documentation hereby submitted, constitutes fraud and may be subject to prosecution and/or imposition of civil money penalties by the federal government. My medical records are available for review.

PRESCRIBING PHYSICIAN SIGNATURE | DATE SIGNED

TYPE OR PRINT PHYSICIAN NAME | PHYSICIAN MEDICARE ID NUMBER | TELEPHONE NUMBER

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0864

ATTENDING PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY FOR HOME OXYGEN THERAPY *(Legible handwritten entries acceptable)*

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HCFA, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Patient's Name, Address, and HIC No.

Supplier's Name, Address, and Identification No.

Certification: ☐ Initial ☐ Revised ☐ Renewed

INFORMATION BELOW TO BE ENTERED ONLY BY PHYSICIAN OR PHYSICIAN'S EMPLOYEE

1. Pertinent Diagnoses, ICD-9-CM Codes, and Findings - CHECK ALL THAT APPLY:

☐ Emphysema (492.8)
☐ COPD (496)
☐ Cor Pulmonale (416.9)
☐ Interstitial Disease (515)
☐ Other _____ Specify _____ Code
☐ Chronic Obstructive Bronchitis (491.2)
☐ Chronic Obstructive Asthma (493.20)
☐ Congestive Heart Failure (428.0)
☐ Secondary Polycythemia (289.0)
☐ Hematocrit 57% or more Yes☐ No☐

2.A. I last examined this patient for this condition on: ____/____/____ Month Day Year

2.B. Home oxygen prescribed: ____/____/____ Month Day Year

2.C. Estimated length of need: ☐1-3 months ☐4-12 months ☐ Lifetime

A. Results of Most Recent Arterial Blood Gas and/or Oxygen Saturation Tests (Patient Breathing Room Air)

	PO2	O2 Saturation	Date
(1) At Rest			
(2) Walking			
(2) Sleeping			
(3) Exercising			
(4) Other :			

3.C. Physician/Provider Performing Test(s) *(Printed/Typed Name and Address)*:

3.B. If performed under conditions other than room air, explain:

NOTE: If PO2 Level exceeds 59 mm Hg or the arterial blood saturation exceeds 89% at rest on room air, the claim will be disallowed without compelling medical evidence. Check block ☐ if you have attached a separate statement on your letterhead of additional documentation.

4. Oxygen Flow Rate : _____ Liters per minute ☐ Continuous (24 hrs/day)

☐ Noncontinuous (Enter hrs/day): _____ Walking _____Sleeping _____Exercise Program _____Other (specify) _____

Oxygen Equipment Prescribed If you have prescribed a particular form of delivery, check applicable block(s). Otherwise leave blank.

A. Supply System

(1) Stationary Source ☐ Concentrator ☐ Compressed Gas ☐ Liquid Oxygen ☐ Other

(2) Portable or Ambulatory Source ☐ Liquid Oxygen ☐ Compressed Gas ☐ Other _____

B. Delivery System

☐ (1) Nasal Cannula
☐ (2) 02 Conserving Device
☐ Pulse 02 System
☐ Reservoir System
☐ Other _____
☐ (3) Tranetracheal Catheter
☐ (4) Other _____

If you have prescribed a portable or ambulatory system, describe activities/exercise that patient regularly pursues which require this system in the home and which cannot be met by a stationary system (e.g., amount and frequency of ambulation).

CERTIFICATION

THE PATIENT HAS APPROPRIATELY TRIED OTHER TREATMENT MEASURES WITHOUT SUCCESS. OXYGEN THERAPY AND OXYGEN EQUIPMENT IS PRESCRIBED IS MEDICALLY INDICATED AND IS REASONABLE AND NECESSARY FOR THE TREATMENT OF THIS PATIENT. THIS FORM AND MY STATEMENT ON MY LETTERHEAD ATTACHED HERETO HAS BEEN COMPLETED BY ME, OR BY MY EMPLOYEE AND REVIEWED BY ME. THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Attending Physician's Signature: *(A STAMPED SIGNATURE IS NOT ACCEPTABLE)*

Date:

Physician's Name, Address, Telephone No., and Identification No.:

ATTACHMENT D

PHYSICIANS PRESCRIPTION FORM

DATE. _____

Patient's Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

AMBULATORY AIDS
___Cane: ___Straight ___Quad
___Walker: ___ Std. Folding ___Lt. Wt.
___Crutches: ___Adult ___Pediatric

DECUBITUS CARE EQUIPMENT
Pt. subject to decubitus ulcers. Dr. supervising
X Decubitus Care Wheelchair Pad
___Decubitus Care Bed Mattress

BEDS & ACCESSORIES
___Egg Crate Mattress
___Full Electric Hospital Bed
___Hospital Bed Side Rails
___Orthopaedic Bed
(Mattress and Box Springs)
___Bed Board
___Trapeze

PATIENT LIFTS
___Seat Lift Chair
___Hoyer Lift
___Lift Sling

PNEUMATIC APPLIANCE/LYMPHADEMA PUMP
___Pneumatic Compressor
Appliance _____

TRACTION
___Pelvic (lbs_____)
___Cervical (lbs_____)

ORTHOPEDICS
___Soft Cervical Collar
___Hard Cervical Collar
Therapeutically Nec. X Lumbosacral Support
___Molded Lumbosacral Support
___Lumbosacral Corset (Hip size___)
___Spiral Knee Support
Therapeutically Nec. X Hinged Knee Support
___Neoprene Knee Sleeve
___Elastic Ankle Support
___Elastic Elbow Support
___Elastic Wrist Support
___Cock-up Wrist Splint

Other _____

_____

BATH AND TOILET AIDS
___Tub Security Rails
___Elevated Toilet Seats
___Portable Home Whirlpool
___Hand & Foot Whirlpool
___Adjustable Std. Commode
___3-in-1 Commode

HEAT/COLD THERAPY
___Electric Moist Heat (Thermaphores)
___Large ___Medium ___Cervical
___Electric Dry Heat
___Hydrocollator Units
___Std. Set ___Cervical Set
___Colpaks (size_____)

OXYGEN
___Oxygen Concentrator
___Portable Oxygen System
___Nebulizer
___IPPB Machine

PILLOWS
___Std. Cervical Pillow
___Cervical Pro Pillow
___Bed Wedge
___Sacrobeck-Back Support Cushion

ELECTROTHERAPY
___Portable TENs Units
___Portable Muscle Stimulator

WHEELCHAIRS/GERIATRIC CHAIRS
___Geriatric Chair
___Standard Wheelchair
(please note Specifications)
___Std. Weight ___Lightweight
___Foot rests ___Legrests
___Fixed Arms ___Removable Arms
___Other _____

MISCELLANEOUS SUPPLIES
___Home Blood Pressure Monitors
___Home Blood Glucose Monitors
___Exercise Bike
___Exercise Rower
___Paraffin Wax Bath
___Penebrator

Physician's Name _____

Address _____ _____ Phone _____

City _____ State _____ Zip _____

Signature _____ License Number _____

ATTACHMENT E

Congressional Research Service • The Library of Congress • Washington, D.C. 20540

August 15, 1991

TO : House Ways and Means Subcommittee on Oversight
Attention: Jeff Fox

FROM : American Law Division

SUBJECT : Congress' Power to Limit Commercial Speech of Certain Medicare Providers

This memorandum is in response to your inquiry with respect to whether Congress could deny Medicare payments to certain providers of equipment to Medicare eligible individuals on the basis of the marketing techniques of the providers. That is, as we understand it, the Committee is concerned that certain companies are engaged in telemarketing activities directed toward those persons eligible for Medicare coverage. The companies telephone these persons to ascertain whether they have medical problems of certain sorts. If any of them do, he is told he is eligible for Medicare reimbursement for equipment that the companies sell and that will alleviate the ailment. In fact, the Medicare recipient is responsible for a certain percentage of the cost of the item. If the recipient indicates a desire to obtain the item, the company sends the requisite papers to the individual's doctor who must sign off on the purchase of the device in order for Medicare to reimburse the company for the major portion of the cost.

The Committee is concerned, first, that the companies are misleading the patients with respect to the part of the costs they must bear, and, second, that the patients may be sold equipment which they do not need. The question is whether, by law, Congress could provide that companies that engage in such telemarketing activities would have their provider numbers revoked, i.e., would be denied participation in Medicare reimbursement for the provision of supplies and services.

For reasons to be elaborated below, we think that the congressional action would encounter no successful constitutional challenge. The companies' speech is commercial speech, which is entitled to less First Amendment protection than is most other expression. Under the standards the Supreme Court has enunciated, commercial speech may be regulated or barred because it is either misleading or because the governmental interest in suppressing it is supported by a substantial interest. The speech with which the Committee is concerned, first, is asserted to be misleading, and, second, takes place in an environment admitting of little if any supervision to prevent fraud, false speech, or overbearing activities.

For years, commercial speech was unprotected by the First Amendment. *Valentine v. Chrestensen*, 316 U.S. 52 (1942); *Breard v. City of Alexandria*, 341 U.S. 622 (1951). Beginning in the mid-1970s, however, the Court, over strenuous objection on and off the Court, extended a limited but significant degree of protection. Because commercial speech is hardier than speech relating to politics, art, religion. and science and because the former is more subject to empirical verification of truth than is the latter, commercial speech does not enjoy full protection. Nevertheless, if commercial speech neither proposes an unlawful transaction nor is misleading, governmental attempts to ban it or to regulate it disadvantageously must pass a balancing test; that is, the governmental interest must be substantial, the governmental ban or regulation must directly advance the interest asserted, and the ban or regulation must not be more extensive than is necessary to serve the interest. *Central Hudson Gas & Electric Co. v. PSC*, 447 U.S. 557, 563, 564, 568-571 (1980).

Before subjecting the proposal to this test, however, although it may perhaps be a little unusual, we should discourage the Committee from reliance upon two other grounds, which facially appear to offer firmer support for the proposal. First, it may be suggested that the government, in the dispensation of its funds, may simply deny money to recipients who engage in speech that government does not like. *Rust v. Sullivan*, 111 S.Ct. 1759 (1991), would offer the most direct precedent for this proposition. There, the Court held that planned parenthood clinics which accepted federal money to promote family planning could be barred from discussing abortion with pregnant patients, even should they inquire. But this case may prove to offer only ephemeral support.

Thus, it has long been settled that "even though a person has no 'right' to a valuable governmental benefit . . . [i]t may not deny a benefit to a person on a basis that infringes his constitutionally protected interests . . . ." *Perry v. Sindermann*, 408 U.S. 593, 597 (1972). See also *Speiser v. Randall*, 357 U.S. 513 (1958). In *FCC v. League of Women Voters*, 468 U.S. 364 (1984), the Court invalidated a provision that banned editorializing by public television stations that received federal subsidies; the government could restrict the uses for which its moneys were deployed, said the Court, but it could not similarly restrict the uses to which a recipient applied its own resources. Differences inhere between *Rust* and *League of Women Voters*, but the distinguishing of the latter by the former is somewhat attenuated. Efforts to extend *Rust* beyond its abortion context, therefore, may be problematic.

However this doctrinal issue is resolved, the committee should be aware that both Houses of Congress have, so far separately, voted to overturn the counseling ban which *Rust* upheld.[1] These votes, of course, are directed to the

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[1] The House of Representatives has passed H. R. 2797, the fiscal 1992 appropriations bill for Labor, HHS, and Education, containing a provision to ban spending of appropriated funds to enforce the regulations forbidding abortion counseling. The Senate has passed S. 323, which would directly overturn the regulations, and the House of Representatives has pending before it when it returns in September a comparable bill, H. R. 3090.

substance of the dispute, the ban on abortion counseling, rather than to the constitutional analysis by which the Court sustained the regulations. But it is fair to say that an effort to rely on this same analysis at the same time Congress is moving to reverse the underlying regulations would likely be met with some skepticism.

Second, recourse to *Posadas de Puerto Rico Assocs. v. Tourism Co. of Puerto Rico*, 478 U.S. 328 (1986), might be attempted. In that case, a closely divided Court upheld a ban on the advertising of casino gambling within Puerto Rico while it was permissible to advertise outside Puerto Rico. The Court, through then-Justice Rehnquist, reasoned that "the greater power to completely ban casino gambling necessarily includes the lesser power to ban advertising of casino gambling." Id., 345-346. That is, if government may ban the activity, it may instead take the supposedly less intrusive step of banning advertising of the activity. Now, since the Federal Government could decide not to support through Medicare the provision of the equipment being advertised, could deny funding under any circumstances, may it not instead take the lesser step of refusing to reimburse purchases of the equipment arranged through the questioned telemarketing activities?

It is doubtful that *Posadas* is available for extension outside its immediate environment. Generalizing its logic - the greater power includes the lesser - would vitiate First Amendment protection of commercial speech. For all practical purposes, the governmental power to prohibit commercial activity is plenary. Save for those few activities which are independently protected by specific constitutional provisions, there is only a weak rational basis standard of review for economic regulation. Therefore, all the limitations on commercial speech that the Court previously has struck down should have been upheld, if the *Posadas* proposition has general application.[2] Moreover, there is doubt the Court intended *Posadas* to reach as far as this extension. At least purportedly, it also relied on the *Central Hudson* standards to which we alluded above, id., 340-344, and in *Board of Trustees v. Fox*, 492 U.S. 469 (1989), the Court, while weakening one of the standards, referred to them as the applicable test and expressly stated that the rational basis standard was not the test in commercial speech cases.

Whatever *Posadas* may mean, then, it is doubtful it provides the proper analysis for evaluating the Committee's proposal.

The proper analysis of the proposal must, we think, proceed from the *Central Hudson* standards. The informational function of advertising is the First Amendment concern; it is the hearer interest, not the speaker's interest, that

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[2] Of course, this is not invariably true. The abortion advertising protected in *Bigelow v. Virginia*, 421 U.S. 809 (1975), would remain protected as long as *Roe v. Wade*, 410 U.S. 113 (1973), continues to be the law. The advertising of contraceptives would continue to be protected, *Bolger v. Youngs Drug Products Corp.*, 463 U.S. 60 (1983), so long as *Carey v. Population Services Intl.*, 431 U.S. 678 (1977), remains valid.

is the focus of the constitutional calculus. That is, because the Court shies away from evaluating the First Amendment interests of individuals in the corporate form, it has looked to the interests of those to whom speech is directed. That approach is exemplified in the political speech context, *First National Bank of Boston v. Bellotti*, 435 U.S. 765 (1978), as well as in the commercial speech area. *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748 (1976). Consumer interest in receiving factual information about prices, of prescription drugs in *Virginia Pharmacy*, could be as high as the public's interest in receiving political information, and in any event price competition and access to information about it is in the public interest. Id., 763-764 (consumer interest), 764-765 (social interest), 766-770 (justification for ban on advertising prices).

If, therefore, advertising or other commercial speech does not accurately inform the public about the matter which it addresses, it can be suppressed or regulated. *Central Hudson*, supra, 447 U.S., 563, 564. For example, in *Friedman v. Rogers*, 440 U.S. 1 (1979), the Court upheld a state ban on the use of trade names in the practice of optometry because the state agency had determined that consumers might be misled about the identity of the personnel in a particular location. The Court did not closely evaluate the basis for the agency's decision nor scrutinize the standards which it applied. That the potential existed was sufficient.

Of greater relevance is the decision in *Ohralik v. Ohio State Bar Assn.*, 436 U.S. 447 (1978). Upheld in this case was state bar discipline imposed upon an attorney for personally soliciting legal business from two accident victims. The attorney had personally visited each of the victims and obtained from them the right to represent them in suing for compensation for their injuries. Attorney advertising as a form of commercial speech has been protected in a number of cases as affording consumers access to accurate information about their legal rights.[3] Distinguishing between advertising generally as a source of information to persons about their entitlement to legal representation and the activity of which the attorney here stood accused, the Court spoke in words which seem as well to apply to the practice in question.

> Unlike a public advertisement, which simply provides information and leaves the recipient free

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[3] *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977)(lawyer advertising of prices charged for performance of routine legal services); *In re R. M. J.*, 455 U.S. 191 (1982)(striking down bar's rigid prophylactic rules on form of lawyer advertising in absence of showing it was misleading or that rules served some other important interest); *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985)(protecting use of illustrations in advertising offering to represent Dalkon Shield victims); *Shapero v. State Bar of Kentucky*, 486 U.S. 466 (1988) (voiding ban on solicitation letters targeted at specific categories of potential clients); *Peel v. Illinois Attorney Registration & Disciplinary Comm.*, 110 S.Ct. 2281 (1990)(voiding ban on attorney holding himself out as a certified civil trial specialist).

> to act upon it or not, in-person solicitation may exert pressure and often demands an immediate response, without providing an opportunity for comparison or reflection. The aim and effect of in-person solicitation may be to provide a one-sided presentation and to encourage speedy and perhaps uninformed decisionmaking; there is no opportunity for intervention or counter-education by agencies of the Bar, supervisory authorities, or persons close to the solicited individual. The admonition that "the fitting remedy for evil counsels is good ones" is of little value when the circumstances provide no opportunity for any remedy at all. In-person solicitation is as likely as not to discourage persons needing counsel from engaging in a critical comparison of the "availability, nature, and prices" of legal services, . . .; it actually may disserve the individual and societal interest . . . in facilitating "informed and reliable decisionmaking." Id., 457-458 (footnote and case citations omitted).

While the Court also emphasized the governmental interest in maintaining standards among the members of the licensed bar, an interest absent in the immediate case, there is no doubt that its evaluation of the low level of protection to be accorded the solicitation engaged in by Ohralik was the decisive factor in reaching its decision.[4] That is, the interest of the speaker, an individual speaker this time, was low level, whereas it was a permissible judgment that the hearer interest would be furthered by regulating face-to-face solicitation.

Applying the precedents to the proposal of the Committee, we can see that the same standards are pertinent. The Committee has already identified one misrepresentation in the telemarketing presentation; the sales pitch is that Medicare will bear the entire cost of the equipment, whereas in fact a percentage is the responsibility of the patient. In other respects, the presentation of the companies is unsupervised; one cannot know what kinds of representations are made to the individuals solicited, what promises of relief and well being. Only the patient's doctor is a possible intermediary, and it may or may not be in his interest or in his concern to play any role other than passively to sign the forms mailed to him.

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[4] Contrarily, one should note *In re Primus*, 436 U.S. 412 (1978), decided the same day, in which the Court struck down disciplinary action imposed on a public interest, nonprofit organization attorney for engaging in essentially the same in-person solicitation of persons to bring actions of a constitutional nature. The absence of pecuniary gain as a motive and the existence of a strong hearer interest in recognizing and pursuing a course of action for the protection of rights were significant differences.

The governmental interest could well be said to be substantial. The money paid out of public funds for equipment that is unneeded or of less than palliative effect may be substantial, and, absent the solicitations, it would go to other purposes. Inasmuch as the purpose of Medicare is the protection of the health and security of eligible persons, congressional action aimed at protecting them from acting on the basis of misrepresentations, or at least protecting them from the reasonable prospect of being subjected to misrepresentations, would appear to be a permissible and even laudatory purpose.[5]

Too, it must be noted that the governmental action contemplated is not a direct, mandatory ban on such telemarketing for these devices. The practice would be discouraged through a refusal to pay for equipment sold in this manner. Companies would remain free to solicit business among non-Medicare eligible individuals and, even, among eligible individuals if they would but give up the government subsidy. The congressional action, thus, would be narrowly conceived and focussed.

Our conclusion is that the case law of commercial speech lends strong support to the validity of the proposal and that, so long as the rationale of the proposal is limited to the area of prevention of misrepresentation and potential misrepresentation, such an enactment is unlikely to encounter a judicial veto.

Johnny H. Killian
Senior Specialist
American Constitutional Law

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[5] One would want to take care not to stray too far from a protection from misrepresentation basis. Benevolence may stray into paternalism, and the case law is clear that guiding or encouraging people to do what government thinks is better for them than some other course of action is not a permissible interest. See *Central Hudson*, supra, in which a ban on utility advertisements "intended to stimulate the purchase of utility services" was held unjustified by an asserted interest in energy consumption and avoidance of subsidization of additional energy costs by all consumers. See also *Linmark Associates v. Township of Willingboro*, 431 U.S. 85 (1977)(voiding ban on "For Sale" signs on private lawns to prevent "fear psychology" leading to "white flight" in racially transitory neighborhood).

Blue Shield

ATTACHMENT F

Prescription For:
☐ Initial
☐ Recertification
☐ Exchange of Equipment

Form Approved OMB No. 0938-0

Certificate of Medical Necessity

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be completed by the beneficiary's physician and returned to us with a completed Medicare claim form.

Patient's Name_____ Health Insurance Claim No._____

Diagnosis _____

Date this equipment prescribed_____ Equipment will be needed for _____ months. Prognosis_____

This prescription applies to rental period from: Month_____ Day_____ Year_____ to Month_____ Day_____ Year_____

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachments or features, or equipment not included below should be listed in the space provided.

	YES	NO	
☐ Hospital Bed (Answer B)	☐	☐	A) Is the patient bed confined?
☐ Hospital Bed—Variable Height (Answer B)	☐	☐	B) Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed?
☐ Electric Hospital Bed (Answer C, D)			
☐ Side Rails (Answer E)	☐	☐	C) Does the patient's condition require frequent and/or immediate changes in body position?
☐ Commode—Standard (Answer A, F, N)			
☐ Commode—Adjustable (Answer A, F, N)	☐	☐	D) Can the patient operate the controls himself?
☐ Trapeze Bar (Answer A, G, H)	☐	☐	E) Is the patient disoriented at any time?
☐ Alternating Pressure Pad (Answer I, J)	☐	☐	F) Is the patient room confined?
☐ Wheelchair—Standard (Answer K)	☐	☐	G) Is there a need for the patient to sit up due to a respiratory condition, etc.?
☐ Wheelchair with Elevating Legrests (Answer K)	☐	☐	H) Is there a medical need for a change in body position?
	☐	☐	I) Is the patient susceptible to decubitus ulcers?
☐ Walker (Answer L, M)	☐	☐	J) Are you supervising the use of pressure pad?
☐ Walker—Folding (Answer L, M)	☐	☐	K) Is the patient's condition such that the alternative would be bed or chair confinement?
☐ Walker—Adjustable (Answer L, M)			
☐ Cane (Answer L, M)	☐	☐	L) Does the patient's condition impair ambulation?
☐ Quad Cane (Answer L, M)	☐	☐	M) Is the walker used for therapy?
	☐	☐	N) Is the patient confined to floor without bathroom facilities?

* If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze bar, etc., please explain why both are medically necessary.

_____

_____

Items not included above and diagnosis or condition which warrants equipment.

_____

_____

_____

If equipment is not used in patient's home, please indicate the name and address of the facility where the patient resides. (Print or type.)

_____

_____

SIGNATURE OF THE PHYSICIAN CERTIFIES THAT THE ABOVE REPRESENTS HIS JUDGEMENT OF THE PATIENT'S NEED FOR THE EQUIPMENT.

IC663-R 4-87

IMPORTANT: *This form must be signed and dated by prescribing physician* before the equipment may be considered for payment. Print or type.

Physician's Name _____

Physician's Phone No. _____

Physician's Address _____

Physician's Signature _____

Date _____

ATTACHMENT G

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

EAST HEALTH CARE FINANCING ADMINISTRATION

December 27, 1990

Need Help? Contact:

Pennsylvania Blue Shield
1800 Center St.
P.O. Box 890065
Camp Hill, PA 17089-0065
Telephone 717-763-3601
Toll Free 1-800-382-1274

Assignment was taken on your claim for $ 240.00 from
Allstate Medical Equipment I. (See item 4 on back.)

		Billed	Approved
1 Durable Equipment (E0190)	Nov 30,1990	$ 75.00	$ 60.51
Approved Amount limited by item 5c on back			
1 Durable Equipment (E0189)	Nov 30,1990	$ 20.00	$ 5.09
Approved Amount limited by item 5c on back			
1 Durable Equipment (E0730)	Nov 30,1990	$ 145.00	$ 0.00

Payment denied because the supplier did not obtain a written order from your doctor prior to the delivery of this item.

Total Approved Amount	$ 65.60
Medicare Payment (80% of the approved amount)	$ 52.48

If you are no longer using this equipment, please notify us immediately at 1-800-382-1274.

Under the current law, we have reduced your Medicare payment by 2 percent for services you received between November 1, 1990 and December 31, 1990. Since your doctor/supplier took your claim on assignment, the doctor/supplier agrees to accept this lower payment. You will not be affected by the 2 percent reduction.

We are paying Allstate Medical Equipment I $ 51.43 for this installment.

You are responsible to the physician/supplier for the difference of $ 13.12 between the approved amount for this installment and the actual

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this, you must write to us before Jun 27, 1991 (See item 1. on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. Claim Control No.

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

EAST HEALTH CARE FINANCING ADMINISTRATION

May 09, 1991

Need Help? Contact:

Pennsylvania Blue Shield
1800 Center St.
P.O. Box 890065
Camp Hill, PA 17089-0065
Telephone 717-763-3601
Toll Free 1-800-382-1274

Assignment was taken on your claim for $ 535.00 from
Allstate Medical Equipment I. (See item 4 on back.)

		Billed	Approved
1 Supply/prosthesis (E0730)	Dec 30,1990	$ 535.00	$ 419.27

Approved Amount limited by item 5c on back

Allstate Medical Equipment I agreed to charge no more for the approved services than the amount approved by Medicare.

Total Approved Amount	$ 419.27
Medicare Payment (80% of the approved amount)	$ 335.42

This is an adjustment of a claim previously processed on Jan 23, 1991 and reflects corrected processing. Any amount withheld reflects the amount paid on the original claim.

Under the current law, we have reduced your Medicare payment by 2 percent for services you received between November 1, 1990 and December 31, 1990. Since your doctor/supplier took your claim on assignment, the doctor/supplier agrees to accept this lower payment. You will not be affected by the 2 percent reduction.

We are paying a total of $ 328.71 to Allstate Medical Equipment I.

You are responsible to the physician/supplier for the difference of $ 83.86 between the approved amount and the Medicare payment.

If you have other insurance, it may help with the part Medicare did not pay.

Do not accept durable medical equipment without discussing the need for

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this, you must write to us before Nov 09, 1991 (See item 1. on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the: .

Medicare Claim No.

Claim Control No.

ATTACHMENT H

Congressional Research Service • The Library of Congress • Washington, D.C. 20540

MEMORANDUM June 18, 1991

SUBJECT : **Medicare Payment for Durable Medical Equipment**

FROM : Kathleen M. King
Specialist in Social Legislation
Education and Public Welfare Division

This memorandum provides information about Medicare payment for durable medical equipment (DME). It discusses current Medicare reimbursement for DME and provides a brief legislative history of DME reimbursement.

Current law does not provide an inclusive definition of DME. Section 1861(n) of the Social Security Act specifies that DME includes ". . . iron lungs, oxygen tents, hospital beds, and wheelchairs (including power-operated vehicles) . . . used in a patient's home, including an institution used as his home . . . ." DME also includes "medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but excluding drugs and biologicals)."[1]

Current Reimbursement for Durable Medical Equipment

Medicare currently pays for DME on the basis of a fee schedule. Reimbursement is the lower of 80 percent of the actual charge for the item or the fee schedule amount. Within the fee schedule, there are five categories of DME. Each category has separate reimbursement principles, although the principles for some categories are similar. The five categories are as follows:

[1]Section 1861(m)(5) of the Social Security Act.

This memorandum was prepared by the Education and Public Welfare Division to enable distribution to more than one congressional client.

- Inexpensive or other routinely purchased DME;[2]
- Items requiring frequent and substantial servicing;
- Customized items;
- Other items of DME (frequently referred to as the "capped rental" category); and
- Oxygen and oxygen equipment.

Prior to the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), prosthetics and orthotics were also included in the DME fee schedule. Section 1861(s)(9) of the Social Security Act defines prosthetics and orthotics as "leg, arm, back and neck braces, and artificial legs, arms and eyes." As with DME, this definition is not inclusive.

The OBRA 90 established reimbursement principles for prosthetics and orthotics under a separate section of law. Although a new section of law was created for prosthetics and orthotics, the new reimbursement principles established for prosthetics and orthotics remained identical to those established under the DME fee schedule. The primary reason a separate section of law was established for prosthetics and orthotics was to exempt them from DME reimbursement changes made in OBRA 90. (The following discussion of DME reimbursement principles includes prosthetics and orthotics.)

Medicare law specifies detailed reimbursement principles for DME.[3] Chart 1 shows the key components of the fee schedule and describes how they affect each category of equipment; the following discussion provides more explanation of these components.

Fee Schedule Basis

The basis for determining the fee schedule is established in law for each type of equipment. For most categories of equipment, the average Medicare reasonable charge is the basis from which fee schedule payments are calculated. Under reasonable charge reimbursement, payment is set at the lowest of the actual charge, the customary charge, the prevailing charge in the locality, or the inflation indexed charge (IIC) for that item.

Other reimbursement mechanisms are specified for other types of equipment not subject to the reasonable charge criteria. For example, the basis

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[2]This category of equipment is defined as equipment costing less than $150 or which is purchased at least 75 percent of the time.

[3]The DME fee schedule is contained in Section 1834(a) of the Social Security Act; reimbursement principles for prosthetics and orthotics are specified in Section 1834(h).

of payment for items requiring frequent and substantial servicing is the average charge. For another category of equipment, customized items, carriers are permitted to determine the appropriate payment amount without regard to average or reasonable charges.

The fee schedule basis for "capped rental" equipment is more complicated than for other categories. Originally, the basis for determining fee schedule payments for capped rental equipment was the average of submitted purchase prices on assigned claims during the base period.[4] OBRA 90 altered this provision by setting the basis equal to the average of the purchase prices submitted for assigned claims submitted during the base time period, minus the percentage by which the average of the reasonable charges for submitted claims is lower than the average of purchase prices submitted for items during the last 9 months of 1988.

Implementation of this provision was originally slated for January 1, 1991, but was delayed until June, 1991 because of questions about the validity of claims data.[5] This provision was included in OBRA 90 because of congressional concerns that the fee schedule basis for capped rental items was too high and thus resulted in excessive Medicare payments for these items. Its implementation is projected to reduce payments for capped rental items by approximately 20 to 25 percent.

Base Time Period

Current law specifies the time period used to calculate the basis of the fee schedule for each category of equipment. The most common base period is from July 1, 1986 to June 30, 1987, updated by the Consumer Price Index for Urban Consumers (CPI-U) to December, 1987, which is used for three categories of DME.

Rental or Purchase

Some categories of DME may only be rented, some may only be purchased, and some may be either rented or purchased. For example, customized items may only be purchased because they are specifically fitted for an individual and can not be used by anyone else.

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[4]In the case of assigned claims, the supplier agrees to accept 80 percent of the Medicare fee schedule payment as payment in full. The beneficiary is liable for 20 percent coinsurance, but not for any amount by which the supplier's charge exceed the fee schedule amount.

[5]Payment limits were implemented retroactively to May 1, 1991.

Regional or National Limits on Payment

Currently, most categories of DME will be subject to national limits on payments in 1993.[6] These limits are being phased-in, beginning in 1991, and will be fully implemented by 1993. During the phase-in period, fee schedule payments are made partially on the basis of local payment amounts and partially on the basis of national payments. In 1991, local payments account for 67 percent and national payment amounts constitute 33 percent of the fee schedule payment. Those percentages will be reversed in 1992. In 1993, the fee schedule payment is equal to the national payment amount.

Two categories of DME are not subject to these limits: customized items and prosthetics and orthotics. Customized items are not subject to any payment limits, while prosthetics and orthotics are subject to regional payment limits, beginning in 1992 and fully implemented in 1994.

Payment Floors and Ceilings

The national limits on payments contain upper and lower limits (referred to as ceilings and floors) on payments. The ceiling is equal to 100 percent of the weighted average of local payment amounts and the floor is equal to 85 percent of the weighted average of local payment amounts. These limits took effect in 1991.

The floors and ceilings applied to the regional payment limits for prosthetics and orthotics vary somewhat from those used for national payment limits. The limits do not take effect until 1992. In 1992, the floor for prosthetics and orthotics is the same--85 percent of the weighted average of the local payment amount, but the ceiling is higher--125 percent of the weighted average. In addition, the limits differ in 1993 and subsequent years, when they are set at 90 percent and 120 percent of the weighted average of local payment amounts.

1991 Update

The 1991 fee schedule update for most categories of DME is the CPI-U minus 1, or 3.7 percent, as shown in chart 1. Note that the 1991 update is applied to fee schedule payments set during the base period, rather than to more current charge data. The 1991 update is the first since the fee schedule was implemented in 1989.

Prosthetics and orthotics did not receive an update in 1991, and one piece of prosthetic and orthotic equipment, a transcutaneous electrical nerve stimulator (TENS), was subject to a 15 percent reduction in fee schedule payments from April 1, 1990 through December 30, 1990. TENS devices were subjected to an additional 15 percent reduction in 1991.

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[6]National limits on payments were enacted by OBRA 90. They replace the regional limits enacted in OBRA 87.

Other Provisions

Useful Lifetime for Rental Items. As originally enacted, payment for categories of equipment that could only be rented was made on a monthly basis. In the case of items requiring frequent and substantial servicing, monthly rental payments continued as long as the equipment was needed. In the case of capped rental items, monthly payments were made for 15 months, after which one payment was made every subsequent 6 months for maintenance and servicing of the item. In both cases, no provision was made for replacement of the item.

The OBRA 90 permitted the Secretary to establish a useful lifetime for these types of equipment, and to establish a new cycle of monthly payments for capped rental items. A useful lifetime of 5 years was established, unless the Secretary determines that 5 years is not appropriate for an individual item. In that case, the Secretary is to establish an alternative reasonable lifetime.

Limitation on Payment Amounts for Capped Rental Items. Prior to OBRA 90, monthly payments for capped rental items were made for a 15-month period, with total payments for an item limited to 150 percent of the purchase price. Each monthly payment was equal to 10 percent of the purchase price. OBRA 90 limited monthly rental payments for these items to 120 percent of the purchase price, with monthly payments equal to 10 percent of the purchase price for the first 3 months, and 7.5 percent of the purchase price for the next 12 months.

Administration of the Fee Schedule

Localities

Localities are geographic areas used to determine payment boundaries. In cases where weighted average local payment amounts are used to determine fee schedule payments, all claims paid in a locality are used to calculate the weighted average.

When the fee schedule was implemented on January 1, 1989, the Secretary established 55 localities.[7] Except for New York and California, each State is designated as a single locality. New York consists of three localities and California has two localities.

Overused Items

The OBRA 90 required the Secretary to develop a list of DME items frequently subject to unnecessary utilization; the list must include seat-lift mechanisms; TENS devices; and motorized scooters. Carriers are directed to determine, in advance, whether payment will be made for items on the

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[7]In contrast, 240 localities are currently used in establishing physician payment rates.

Secretary's list.[6] Thus, DME suppliers must obtain carriers' approval before providing items on the list to Medicare beneficiaries.

Certificates of Medical Necessity

All DME must be prescribed by a physician in order to be reimbursed by Medicare. In addition to a physician's prescription, carriers may require completion of a certificate of medical necessity (CMN) to document that an item is reasonable and medically necessary. OBRA 90 prohibited DME suppliers from distributing completed or partially completed CMNs and established penalties for suppliers who knowingly and willfully distribute forms in violation of the prohibition.

The purpose of this provision was to prohibit DME suppliers from directly marketing DME items to Medicare beneficiaries by providing them with completed CMNs for them to submit to their physicians. Requiring physicians to complete CMNs will also impel them to take a more active role in considering their patients' needs for DME, while simultaneously reducing DME suppliers' ability to influence DME acquisition.

This provision was scheduled to be implemented January 1, 1991, but is not expected to be implemented until July or August, 1991 because of administrative difficulties.

Inherent Reasonableness

The Secretary is permitted to increase or decrease Medicare payments in cases where the payment amount is ". . . grossly excessive or grossly deficient and not inherently reasonable." The Secretary's authority to make these payment adjustments is generally referred to as inherent reasonableness authority.

In order to make a payment adjustment, the Secretary must demonstrate that the payment meets several criteria of inherent reasonableness specified by law. In addition, the Secretary must publish a notice in the *Federal Register* outlining his proposal to reduce or increase payment amounts, the proposed methodology for adjusting the payment amount, and the potential impact of the payment adjustment. The Secretary is also required to provide a 60 day public comment period and to publish a final determination in the *Federal Register*. The final determination must include an explanation of the factors and data the Secretary took into consideration in making the determination.

According to HCFA, the Secretary rarely uses inherent reasonableness authority because the requirements are too stringent and the notice requirements too burdensome to permit easy imposition of inherent reasonableness adjustments. Moreover, the Secretary was prohibited, by law,

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[6]Carriers are typically insurance companies under contract to the Health Care Financing Administration (HCFA) to administer Medicare.

from making inherent reasonableness adjustments to the DME fee schedule prior to January 1, 1991.

Through regulation, the Secretary has delegated authority to carriers to make inherent reasonableness adjustments in localities for nonphysician services.[9] Carriers must meet the same criteria of inherent reasonableness as the Secretary, but the notice requirements imposed on them are less stringent. They must inform affected suppliers of the factors considered in making inherent reasonableness adjustments, evaluate any comments received, and inform affected suppliers of final limits imposed. Limits are effective 30 days after the date of the carrier's notification. They are not required to publish notices in the *Federal Register*, or provide for a formal comment period. In HCFA's view, the less onerous notice requirements should make it easier for carriers to make inherent reasonableness adjustments on a locality-by-locality basis.

Legislative History of DME Reimbursement

From the enactment of Medicare until the passage of the Omnibus Budget Reconciliation Act of 1987, the basic principle underlying DME reimbursement was reasonable charges. Payment under the lease-purchase option was also based on reasonable charge principles.

The Social Security Amendments of 1965, which created the Medicare program, provided Medicare coverage only for rental of DME.[10] The Social Security Amendments of 1967 provided for purchase of DME, while retaining the rental option. Many beneficiaries continued to rent DME.

In 1972, the General Accounting Office (GAO) submitted a report to Congress titled, *Need for Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment Under Medicare*. The report's primary conclusion was that Medicare patients often rented DME for prolonged periods even though purchase would have been justified, based physicians' estimations of the length of time beneficiaries would need the equipment. GAO concluded that savings could be achieved if long term rental could be decreased or eliminated.

The Social Security Amendments of 1972 authorized the Secretary to conduct reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of DME. The Secretary was authorized to conduct experiments in one or more areas to provide for lump-sum purchase of DME where economical, among other things. Further, the Secretary

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[9]42 C.F.R. 405.502

[10]The legislative history of DME reimbursement prior to 1987 is abstracted from: U.S. Dept. of Health and Human Services. Health Care Financing Administration. Office of Research and Demonstrations. *Reimbursement for Durable Medical Equipment*. Health Care Financing Grants and Contracts Report, v. 1, Mar. 1980.

was granted authority to implement national DME reimbursement procedures based on the results of these experiments. Some experiments were conducted, but no national changes in reimbursement policy were implemented.

In the 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments, Congress directed the Secretary to determine whether the expected duration of medical need for DME warranted a presumption that purchase of equipment would be more practical than rental. If the Secretary determined that such a presumption existed, the equipment must be purchased under a "lease-purchase" agreement or other method. The Secretary was also authorized to establish "equitable, economical and reasonable" reimbursement principles.

The Secretary promulgated regulations implementing the lease-purchase provisions in 1980, but they were never implemented.[11] According to HCFA, opposition from the DME industry and operational concerns within HCFA contributed to the decision not to implement these regulations. However, they were subsequently implemented through carrier instructions in 1985.

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87)

Congress created the basic structure of the DME fee schedule described above in OBRA 87, but delayed its implementation until January 1, 1989. According to congressional and Administration sources, impetus for creating the DME fee schedule arose from several sources. In HCFA's view, DME suppliers embraced the fee schedule as a less onerous alternative to the lease-purchase guidelines implemented by HCFA in 1985 and actively participated in congressional development of the new law. Congressional policy makers viewed the DME fee schedule as part of a broader strategy to eliminate reasonable charge reimbursement principles in Medicare Part B and replace them with fee schedules. For example, clinical laboratory services were placed on a fee schedule basis in 1984, and fee schedules were also developed for physician services, including separate fee schedules for radiology and anesthesiology services.

At the time of OBRA 87's enactment, the intended fiscal implications the fee schedule were unclear. HCFA's Office of the Actuary estimated that DME expenditures would rise after the fee schedule was implemented.[12] In contrast, the Congressional Budget Office (CBO) estimated savings, most of which resulted from reduced payments for oxygen, rather than from the fee schedule

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[11]42 C.F.R. 405.11

[12]At the time OBRA 87 was enacted, the Office of the Actuary in HCFA estimated that implementation of the fee schedule in 1989 would increase Medicare outlays by $20 million in FY89, and $70 million in both 1990 and 1991.

itself.[13] However, there is general agreement that achieving substantial reductions in DME spending was not the primary reason the fee schedule was enacted.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89)

Since OBRA 87, Congress has twice made revisions to the DME fee schedule. In OBRA 89, most of the changes were intended to achieve deficit reduction or fine-tune the fee schedule. Regarding deficit reduction, payment updates scheduled to take effect in 1990 were eliminated and payments for seat-lift chairs and TENS were reduced by 15 percent. OBRA 89 also imposed more restrictive ceilings and floors on DME payments than originally enacted in 1987. Taken together, CBO estimated that the OBRA 89 payment reductions would reduce projected outlays for DME by $80 million in 1990, and a total of $690 million from 1990-1994.[14]

A number of other provisions regarding DME were included in the House version of the bill, but were not adopted by the conference committee. Among them were: (1) imposing a national cap on the fee schedule; (2) authorizing the Secretary to make inherent reasonableness adjustments prior to January 1, 1991; (3) authorizing the Secretary to develop a list of overpriced items and empowering him to reduce payments for these items by 15 percent; (4) prohibiting suppliers from distributing completed CMNs; (5) requiring mandatory assignment of DME claims; and (5) establishing a reasonable lifetime for rental items. Some of these provisions were subsequently included in OBRA 90.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90)

As part of a 5 year deficit reduction agreement, CBO estimated that OBRA 90 reduced projected outlays for DME by an estimated $245 million in 1991, and a total of $2.245 billion from 1991-1995.[15] These reductions took several forms, some of which were: (1) a reduction in the 1991 update from CPI-U to CPI-U minus 1; (2) further reductions in TENS payments; (3) a reduction in the base of payments for rental cap items from submitted charges to a base that includes average reasonable charges; and (4) a reduction in total payments for rental cap items from 150 to 120 percent of the purchase price.

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[13]At the time of enactment, CBO estimated that implementation of the fee schedule would reduce projected Medicare outlays by $95 million in FY89 and $215 million in FY90.

[14]U.S. Congress. House. Committee on Ways and Means. *1990 Green Book*. Washington, GPO, 1990. p. 209.

[15]U.S. Congress. House. Committee on Ways and Means. *1991 Green Book*. Washington, GPO, 1991. p. 230.

In addition to deficit reduction measures, there were a few other notable changes in OBRA 90. Except for prosthetics and orthotics, the requirement for regional fee schedules was repealed and replaced with national limits on fees. The purpose of this measure was to reduce regional variations in fees and constrain payments to 100 percent of the weighted national average of payments for that item. In addition, as discussed above, prosthetics and orthotics were removed from the DME fee schedule and placed in a separate section of law. Finally, DME suppliers were prohibited from distributing partially or fully completed certificated of medical necessity.

CHART 1. Medicare Reimbursement for Durable Medical Equipment

	Inexpensive or routinely purchased DME	Items requiring frequent and substantial servicing	Customized items	Other items of DME (capped rental)	Prosthetics and orthotics	Oxygen and oxygen equipment
Examples of items	Commode chairs, electric heat pads, IV poles, bed rails, vaporizers, blood glucose monitors, pacemaker monitors, seat lift chairs	Ventilators, internal positive pressure breathing (IPPB) machines, nebulizers, suction pumps	Customized wheelchairs adapted specifically for an individual	Hospital beds, infusion pumps, walkers, wheelchairs (including power-driven) chairs	Artificial limbs, ostomy supplies	Liquid and gaseous oxygen and various types of oxygen equipment
Fee schedule basis	Average charge for purchase or rental	Average reasonable charge	Determined by the carrier on an individual basis	Average of purchase prices on assigned claims, reduced by the percentage by which average charges is lower than average purchase prices	Average reasonable charge for purchase	Average reasonable charge for purchase

CHART 1. Medicare Reimbursement for Durable Medical Equipment--Continued

	Inexpensive or routinely purchased DME	Items requiring frequent and substantial servicing	Customized items	Other items of DME (capped rental)	Prosthetics and orthotics	Oxygen and oxygen equipment
Base period	July 1, 1986 to June 30, 1987, updated by the CPI-U to Dec. 1987	July 1, 1986 to June 30, 1987, updated by the CPI-U to Dec. 1987	Not applicable	Base period for purchase prices--July 1, 1986 to Dec. 30, 1986, updated by the CPI-U to Dec. 1987. Base period for reasonable charges--Apr. 1, 1988--Dec. 31, 1988	July 1, 1986 to June 30, 1987	Jan. 1, 1986 to Dec. 30, 1986, reduced by 5%, and updated by the CPI-U to Dec. 1987
Rent or purchase	Rental or purchase	Rental only	Purchase only	Rental with option to purchase in first month for power-driven chairs; for other items, option to purchase is offered in the 10th continuous rental month	Purchase only	Not applicable--monthly payment amount made
Regional or national limits	Phased-in national limits, beginning in 1991 and fully implemented in 1993	Phased-in national limits, beginning in 1991 and fully implemented in 1993	Not applicable	Phased-in national limits beginning in 1991 and fully implemented in 1993	Phased-in regional limits beginning in 1992 and fully implemented in 1994	Phased-in national limits beginning in 1991 and fully implemented in 1993

CHART 1. Medicare Reimbursement for Durable Medical Equipment--Continued

	Inexpensive or routinely purchased DME	Items requiring frequent and substantial servicing	Customized items	Other items of DME (capped rental)	Prosthetics and orthotics	Oxygen and oxygen equipment
National floors and ceilings	Floor = 85% of weighted average of local payment amounts; ceiling = 100% of same. Effective: 1991.	Floor = 85% of weighted average of local payment amounts; ceiling = 100% of same. Effective: 1991.	No	Floor = 85% of weighted average of local purchase prices; ceiling = 100% of same. Effective: 1991.	Floor = 85% of average of national purchase prices; ceiling = 125% of same. Effective: 1992. Subsequent year: limits are 90% and 120%.	Floor = 85% of local monthly payment rates; ceiling = 100% of same. Effective: 1991.
1991 update	CPI-U minus 1	CPI-U minus 1	Not applicable	CPI-U minus 1	Zero, except for TENS, for which payment was reduced by 15% from April 1, 1990 to Dec. 31, 1990 and an additional 15% for 1991	CPI-U minus 1
Other provisions		Reasonable lifetime		Reasonable lifetime; limit on rental payments = 120% of purchase price		

COMPARISON OF FEE SCHEDULE AMOUNTS FOR SELECTED ITEMS

Procedure Code	Item Description	Florida Prices	Iowa Prices	California Prices	Colorado Prices	Pennsylvania Price
E0565	Compressor, air power source for equipment which is not self-contained or cylinder driven	$ 32.96 (R)	$ 51.23 (R)	$ 59.01 (R)	$ 26.67 (R)	$ 73.02 (R)
E0570	Nebulizer, with compressor e.g., DeVilbiss Pulmo-Aid	$ 46.86 (R)	$ 26.03 (R)	$ 41.00 (R)	$ 37.41 (R)	$ 75.91 (R)
E0575	Nebulizer, self-contained, ultrasonic	$ 80.76 (R)	$ 71.51 (R)	$ 80.85 (R)	$ 74.22 (R)	$ 78.64 (R)
E0585	Nebulizer, with conductor and heater	$ 49.75 (R)	$ 30.20 (R)	$ 67.42 (R)	$ 69.41 (R)	$ 66.73 (R)
E0600	Suction pump, home model, portable	$ 51.20 (R)	$ 41.02 (R)	$ 70.13 (R)	$ 38.09 (R)	$ 80.68 (R)
E0601	Nasal continuous airway pressure (CPAP) device	$ 92.07 (R)	$ 84.92 (R)	$ 89.87 (R)	$ 94.47 (R)	$ 70.10 (R)
E0606	Postural drainage board	$ 14.27 (R)	$ 10.11 (R)	$ 19.40 (R)	$ 16.79 (R)	$ 15.82 (R)
E0608	Apnea monitor	$136.26 (R)	$210.14 (R)	$230.12 (R)	$173.83 (R)	N/A
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery, e.g., Cascade, Jr.	$ 19.33 (R)	$ 19.33 (R)	$ 18.75 (R)	N/A	$ 54.26 (R)
E0580	Nebulizer, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	$ 8.88 (R)	$ 11.49 (R)	$ 10.45 (R)	N/A	$ 44.61 (R)
E0585	Vaporizer, room type	$ 4.47 (R)	$ 4.84 (R)	$ 31.66 (R)	N/A	$ 31.69 (R)
E0607	Home blood glucose monitor	$ 20.99 (R)	$ 20.22 (R)	$ 20.28 (R)	N/A	$ 26.37 (R)
E0609	Blood glucose monitor with special features e.g., voice synthesizers, automatic timers, etc.	$ 43.16 (R)	$ 57.11 (R)	$ 43.63 (R)	N/A	$ 38.48 (R)
E0610	Pacemaker monitor, self-contained, checks battery depletion; includes audible and visible check systems	$ 31.96 (R)	$ 30.97 (R)	$ 30.97 (R)	N/A	$ 58.46 (R)
E0615	Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems	$ 46.41 (R)	$ 33.89 (R)	$ 33.88 (R)	N/A	$ 60.72 (R)
E0621	Sling or seat, patient lift, canvas or nylon	$ 6.77 (R)	$ 5.57 (R)	$ 5.83 (R)	N/A	$ 10.37 (R)

ATTACHMENT J

KNEE ORTHOSIS (KNEE ACE BANDAGE)
(HCFA Common Procedure Code #L1825)

ITEM	DME SUPPLIER COST	MEDICARE REIMBURSEMENT RATE (AT 80%)		FULL MEDICARE COST	PERCENT PRICE INCREASE
Knee Orthosis (ace bandage)	$4.95	PA	$29.17	$36.46	637%
		DE	36.61	45.77	825%
		MD	77.30	96.62	1,852%
		NJ	28.48	35.60	619%

ELECTRIC HEATING PAD
(HCFA Common Procedure Code #E0215)

ITEM	DME SUPPLIER COST	MEDICARE REIMBURSEMENT RATE (AT 80%)		FULL MEDICARE COST	PERCENT PRICE INCREASE
Electric Heating Pad	$9.68	PA	$53.03	$66.29	585%
		MD	12.80	16.00	65%
		NJ	27.68	34.60	257%
		NY	14.68	18.35	90%

PARAFFIN WAX BATH*
(HCFA Common Procedure Code #E0235)

ITEM	DME SUPPLIER COST	MEDICARE REIMBURSEMENT RATE (AT 80%)		FULL MEDICARE COST	PERCENT PRICE INCREASE
Paraffin Wax Bath	$94.95	PA	$518.64	$648.30	582%
		DE	414.96	518.70	
		MD	148.80	186.00	
		NJ	466.80	583.50	514%
		NY	268.92	336.15	254%

This is a shoe box size heating element that, over a 9-10 hour period, melts a large block of paraffin wax.

* This is an item that is rented over a 15-month period. It is not a purchase.

LUMBAR SACRAL ORTHOSIS
(HCFA Common Procedure Code #L0500)

ITEM	DME SUPPLIER COST	MEDICARE REIMBURSEMENT RATE (AT 80%)		FULL MEDICARE COST	PERCENT PRICE INCREASE
Lumbar Sacral Orthosis	$14.85	PA	$13.69	$92.11	520%
		DE	99.28	124.10	736%
		MD	97.62	122.02	922%
		NJ	95.00	118.75	700%
		NY	182.65	228.31	1,437%

This is an elastic back brace with velcro closures.

DECUBITUS CARE MATTRESSS*
(GEL OR LIQUID FILLED)
(HCFA Common Procedure Code #0190)

ITEM	DME SUPPLIER COST		MEDICARE REIMBURSEMENT RATE (AT 80%)	FULL MEDICARE COST	PERCENT PRICE INCREASE
Decubitus Care Mattress	$50.00	PA	$726.12	$907.65	1,715%
		DE	778.08	972.60	1,845%
		MD	485.76	609.45	1,119%
		NJ	778.08	972.60	1,845%

*This is an item that is rented over a 15-month period. It is not a purchase.

FLOTATION PAD FOR A WHEELCHAIR
(HCFA Common Procedure Code #E0183)

ITEM	DME SUPPLIER COST		MEDICARE REIMBURSEMENT RATE (AT 80%)	FULL MEDICARE COST	PERCENT PRICE INCREASE
Flotation Pad for a Wheelchair	$23.49	PA	$192.77	$240.96	926%
		DE	219.20	274.00	1,066%
		MD	106.12	132.65	465%
		NJ	68.37	85.46	264%
		NY	66.07	82.59	252%